

E. M. GOLDBERG
FAMILY
INFLUENCES
AND
PSYCHOSOMATIC
ILLNESS

*An Inquiry into the Social
and Psychological Background
of Duodenal Ulcer*

WITH A FOREWORD BY ERIC D. WITTKOWER

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*Family Influences and
Psychosomatic Illness*

E. M. GOLDBERG

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AN INQUIRY INTO THE SOCIAL
AND PSYCHOLOGICAL BACKGROUND
OF DUODENAL ULCER

With an Appendix on Psychological Tests
by Victor B. Kanter

Foreword by Eric D. Wittkower

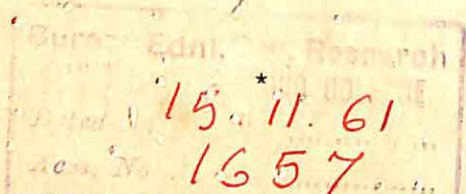


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FOREWORD

Research into the origin of duodenal ulcer, a disorder whose incidence is apparently still increasing, has slowly broadened in approach during the past twenty-five years. Such work is no longer confined, as it once was, to a detailed study of the lining of the gastro-intestinal tract. Over a far longer period, and in line with speculations and observations by outstanding and interested physicians, concern has recently developed about the patient as a person—and often as a person under stress. Still more recently exploration has started of the psychological and sociological aspects of the family environment of such patients, in the search for clues that might in due course provide testable hypotheses and, ultimately, guidance for prevention and treatment.

This book describes an exploratory study in which efforts were made to discover meaningful differences between the family backgrounds of a group of young duodenal ulcer patients and those of a control group. It can be said with certainty that it has more than fulfilled this apparently modest aim. In so doing, however, it has also made contributions to knowledge of a different and much wider kind: in the first place, as to means of overcoming some of the many difficulties of approach and method inevitable in such research; in the second place—and perhaps of still greater value—in providing, with convincing factual detail, important observations on the working of urban family life.

Although, therefore, the findings and conclusions are of direct and obvious concern to those involved in research in psychosomatic medicine—whether that research is clinical, psychological or sociological—they have also a considerable interest to the wider group of general practitioners, physicians, and hospital staff whose need is to improve the advice and help to patients suffering from the particular illness under study. On a still wider basis, because of the scarcity of such direct inquiries, the work can hardly fail to be helpful to those concerned with the

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guidance of families, parents, and young people over some of the familiar if less tangible difficulties standing between them and fulfilment of their rising aspirations for the quality of family life. Finally, because of its factual descriptions of urban life, it provides teaching material for courses on contemporary society.

When clinical research enters the arena of psychological and social study, the outcome can contribute to many fields; and for this special reason the work reported in this book deserves careful attention.

ERIC D. WITTKOWER, M.D.

Department of Psychiatry
McGill University

PREFACE

The investigation into 'Family Relations, Personality Development and Duodenal Ulcer', a part of which is reported in this volume, was carried out by a team of three; a psychiatrist, Dr P. M. Turquet; a clinical psychologist, Mr W. B. Kanter; and the author, a psychiatric social worker. The team collaborated closely during the period of field work, which lasted for about three years, and many of the ideas presented in this book are the result of this combined work and thinking. In addition to contributing invaluable case material Dr Turquet and Mr Kanter have also read and criticized the manuscript. It is, therefore, my first and very pleasant duty to thank my two colleagues for the important contribution they have made to anything that may be of value in this report. However, I alone am responsible for the final content of the book and for its many shortcomings.

But perhaps I owe the greatest debt to the parents, and particularly to the mothers of the patients and control subjects who gave so generously, not only of their time but of themselves. Without their unstinting help this book could never have been written. No names can be mentioned; indeed all the case material quoted has been disguised. The names of persons are fictitious; and external circumstances, such as the actual jobs, the towns in which the parents were born, other places mentioned, and similar items, have been altered so that the families described cannot be recognized. On the other hand their life experiences, behaviour, and attitudes are reported as faithfully as possible.

Since the families whose lives are discussed in this book must remain anonymous, it is not possible to reveal the exact area in which the research was carried out. Thus I cannot thank by name the general practitioner and the hospital doctors whose cooperation and encouragement have made this inquiry possible.

There are, however, some people whose generous help and advice I can acknowledge here, especially my other colleagues at

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the Unit. First of all the Director, Dr J. N. Morris, whose healthy scepticism, particularly in matters psychological, helped throughout to keep the team's feet on the ground; Dr Derek H. Allcorn, to whom I am very grateful for his painstaking and stimulating help with the final preparation of the manuscript; and Mr J. A. Heady, Senior Statistician to the Unit, who took charge of the 'sampling', and whose sound advice I have always greatly appreciated. I also want to thank Professors Aubrey J. Lewis, T. Ferguson Rodger, and Richard M. Titmuss, for reading the manuscript and for making many helpful suggestions. I am much indebted to Dr Elizabeth Bott, whose pertinent and constructive criticism has been of considerable help to me. Last, but not least, I want to thank the secretarial staff of the Unit, and in particular Miss M. M. Alliston, not only for typing and re-typing the manuscript many times with good humour and patience, but for so ably carrying out the rather tedious administrative duties that are inherent in such a piece of research.

CHAPTER I

Introductory

The investigators in this research are asking questions that are both difficult and important. What are the psychological and social factors that may be contributing to the causes of duodenal ulcer, and to its increasing frequency in the population?

Duodenal ulcer in men has increased to 'epidemic' proportions during the last fifty years. Various estimates put the proportion of men aged 45 and over now affected at between 4 and 10 per cent. Perhaps a million persons in Britain today suffer from this malady. The evidence, particularly the figures relating to perforated ulcers, suggests that the increase is a real one and not merely due to better diagnosis and case-finding (Avery-Jones, 1955; Doll and Avery-Jones, 1951; Finer and Fry, 1955; Illingworth, 1944; Jamieson, 1955); Jennings, 1940; Lipetz, 1955; Morris and Titmuss, 1944.

It is very unlikely that this increase in the disease is due to genetic changes alone. Reasons will therefore have to be sought in changes in ways of life and in the environment that have occurred during the last fifty years.

Many physicians and research workers are agreed that emotional factors play an important part in the illness. There is also an increasing acceptance of the hypothesis that family relationships, particularly in childhood, methods of upbringing, and the emotional climate in which the child grows up, are important determinants of the emotional development of an individual and of his mental health in adult life. When we consider the social changes that have taken place during the present century we find that they have been considerable in those areas that most intimately affect personality development and mental health. Families have become smaller, and this has important implications for the interpersonal relations of their members. The pattern

of authority within the family has changed greatly, as have the roles of women inside and outside the family. The bringing-up of children, which used to be governed by definite maxims and standards, has become more tentative and uncertain in its goals. Educational opportunities have increased; but this has not necessarily led to greater fulfilment in adult life, either at work or in the home. These considerations underlie the basic hypotheses of this investigation: that psychological and social forces may have contributed to the increase of duodenal ulcer; and that these are related to changes in the composition of the family, in relationships within the family, and in the methods of bringing up children. This study, therefore, deals primarily with the family background and childhood of ulcer patients. In a later volume it is hoped to relate these familial and childhood factors to the emergence and functioning of the adult personality.

It needs to be stressed at the outset that the investigators are fully aware that psychological and social factors that seem to be significant in the production or development of duodenal ulcer can constitute only part, though possibly an important part, of its overall aetiology. In this report information is presented that relates to the psycho-social factors (to the exclusion of any others) not because these are thought to be the only ones that matter, but because it seemed desirable at this stage of uncertainty to elucidate some of them before attempting to relate them to other important factors, such as physiological predisposition.

Previous Studies

Although a number of studies of the adult personalities of ulcer patients have been published, few investigations have been concerned with the family background and childhood of the patients. Alexander (1952) reports that in studies conducted in the Chicago Institute for Psychoanalysis ulcer patients were found to have a typical 'conflict'. They wished to remain in the dependent, infantile situation—to be loved and cared for—and this wish was in conflict with their adult aspirations for self-sufficiency and independent achievement. Alexander believes that these dependent longings have their roots in lack of satisfaction or actual frustration in early feeding ('oral frustration') and in strong dependencies on parent-figures, first the mother and later the father.

Garma (1950, 1953), who advances a somewhat speculative hypothesis about the genesis of duodenal ulcer, found no definite evidence of actual frustration in early feeding. On the other hand, the mothers of his patients, who were strict and dominant women, resisted attempts of their children to become independent of them. Mittelman and Wolff (1942) state, on the basis of their investigation of 25 duodenal and 5 gastric ulcer patients and 13 controls, that 'the failure of the home in every instance to lend a stable background resulted from a variety of causes—the unhappy married life of the parents, separation or loss of the father during the child's development, early re-marriage of the mother after separation from father; feelings in the child of being rejected by either of both parents or by the foster father; the anxiety of parents who either by restrictions or "coddling" created in the child doubts concerning his adequacy.' Mirsky and his colleagues (1950, 1953), proceeding from the hypothesis that hyper-secretion precedes the ulcer and that some individuals are born with hyper-secreting and others with hypo-secreting stomachs, suggest that such secretory activities will influence food requirements, which, in turn, might affect the mother-child relationship. Thus a baby might react to even the most 'giving' mother as though she were a rejecting one, because of its high gastric activity, and the concomitant increase in its oral needs. In this way, a child's dependent wishes may never have been adequately gratified. Kapp *et al.* (1947) in their investigation of 20 men with peptic ulcers found intense dependent desires in every patient. The origin of such strong dependent wishes was traced either to rejection or spoiling in early childhood, and the ulcer symptoms developed when these infantile cravings were denied in later life.

Most of these studies were not focused on the childhood of the ulcer patients. Two investigations have tried to elucidate childhood experiences that may be related to the emergence of ulcer

¹ Since going to press two small intensive studies, which deal with the family background of children with duodenal ulcer, one British (Goldberg, 1957) the other American (Chapman *et al.*, 1956), have come to my notice. Their findings are remarkably close to the suggestions emerging from our study. For instance, Goldberg comments on the loss of father in over 25 per cent of the cases. Chapman stresses the marked inhibition of aggression in the patients, their close and ambivalent relationship to a restrictive or over-indulgent mother, and their distant and emotionally ineffective relationship to the father.

in later life. Ruesch *et al.* (1948) compared information about 42 Naval personnel and 20 civilians suffering from duodenal ulcer with data reported by other authors on 200 healthy members of the U.S. Navy. The family constellation illustrating the relation of the patients to their parents was reconstructed with the help of the patient's childhood memory . . . A large percentage of the Naval ulcer bearers fall into the pattern of a dominant mother and uninfluential father; in contrast the civilians seem to have had an affectionate and idealized mother who protected the children against an extremely punitive father. Relation to the siblings reveals that ulcer bearers tend to be the younger or youngest children in the family, separated from their next older or younger siblings by a space of several years which isolates them from the rest of the children. The suggestion that the mothers of the ulcer patients were dominant or indulgent women with whom the patients became strongly identified is of considerable interest because it corresponds in some respects with the findings of our own study.

The only British study known to me that is concerned with childhood factors in relation to duodenal ulcer was carried out by Kellock (1951), who compared the early experiences of 250 hospital patients with the condition and 250 patients with other diseases. Unlike Ruesch, he found no differences regarding the position of the patients among the siblings; and the rest of his findings are also entirely negative. There were no differences between the ulcer and other patients in respect of their mother's age when they were born, the position of the patient in the family, death of parents or separation from them, or the frequency of re-marriage of either father or mother.

With the exception of Kellock's, most of these studies inevitably deal with small numbers, and adequate control data are not available. The tentative conclusions that can be drawn from this glance at the investigations so far carried out are that a wide variety of disturbances in family relationships may occur in the childhood of individual ulcer patients. Usually, these factors do not appear to amount to the gross disruption of family life exemplified by 'broken' homes, and it therefore seems that factors that may be associated with the emergence of duodenal ulcer should be sought in more subtle disturbances of family relationships.

One of the difficulties of identifying such potentially pathogenic childhood situations is that we lack knowledge about which family practices and attitudes are customary and 'normal' in our rapidly changing urban society, despite the obvious relevance of such information for Public Health practice. Only quite recently, after this study was completed, have investigations been published in this country in which samples of individuals from specific communities were studied. These studies provide some information about family roles, relationships, and patterns of child upbringing in various urban areas, including Bethnal Green (Robb, 1954; Young and Willmott, 1957; Bott, 1957), Paddington (Spinley, 1953), London (Shaw, 1952) and Liverpool (Mays, 1955). Gorer's study (1955) provides useful information about many aspects of family life in England. Thus outlines of the current norms of behaviour and of commonly held attitudes in sections at least of the community are beginning to emerge, and in the future it may be possible to assess more accurately possible childhood origins of social and psychological elements in various diseases. However, when the present study was undertaken this information regarding practices of child upbringing, parent-child relationships, and family roles typical in urban areas was not available. Moreover, the investigators had come from a clinical background, which inevitably meant that they knew far more about the pathological aspects of family relationships and emotional growth than about the healthy aspects. This study should therefore be regarded as a very tentative exploration of family relationships and their possible pathogenic nature in relation to the emergence of a 'psychosomatic' illness later in life.

Method—the Sample

Since the main concern of the inquiry was the family background of ulcer patients, a number of lads and young men aged from 16 to 25 were selected for study. This age-group may not be typical of all ulcer patients; for duodenal ulcer is diagnosed most frequently between the ages of 35 and 44. On the other hand there is some evidence that symptoms tend to occur long before the patient attends hospital. The incidence of symptoms rises sharply

¹A psychosomatic illness is here defined as one in which psychological factors are commonly held to play an important part in its aetiology.

between the ages of 14 and 20, with a small rise thereafter, until the highest incidence is reached at about 30 years of age (Jamieson *et al.*, 1949).

The main sample consisted of 32 male patients in this age-group who attended the two main hospitals in a part of East London during one calendar year and whose parents lived in Greater London.¹ In each case the diagnosis was made independently of the research team by the clinical staff of the respective hospitals. Patients were taken into the study in the order in which their names appeared in the X-ray or 'operation' records, and may thus be considered reasonably representative at least of young men with serious duodenal ulcer.²

Since the intention was to establish whether the patterns of family relationships found were typical of families whose sons subsequently developed ulcer it was necessary to study a 'control' sample of families whose sons did not have ulcers.³ These controls were chosen from the list of a general practitioner attached to the Research Unit (Backett *et al.*, 1953). They constituted a random sample of 32 men matched for age with the ulcer patients. Twenty-seven of the 32 controls can be considered a satisfactory 'random' sample since they either cooperated immediately when approached (20 cases) or were randomly drawn to make good deficiencies over which the investigators had no control, for example where the young man was away in the Forces, or had moved out of the district (7 cases). The remaining 5 were replacements for families unwilling to cooperate, and they are clearly much less satisfactory as controls since undefined selective

¹ In addition a number of other ulcer patients were studied. They included some students who were attending the Student Health Centre of University College, London; and, since duodenal ulcer is very rare among them, five young women attending hospitals in various parts of London because of this disorder. Although these additional investigations have been most instructive in high-lighting some of the crucial family problems which may be related to ulcer, this report deals only with the results obtained from the study of the 32 hospital patients.

² During the period of a calendar year in which the cases were collected, there were in all 36 young men with duodenal (including pyloric) ulcer, eligible for inclusion in the study. Of these 1 proved to be completely uncooperative. In 3 other cases the mother had died during the young man's childhood, and the information about this period was not sufficiently full for our purposes. The one case of gastric ulcer diagnosed during the year has also been excluded.

³ Two of the young men in the control sample complained of rather vague occasional dyspeptic symptoms during the period of observation.

factors enter. However, as some information about the unco-operative families is available from the general practitioner and from such contacts as the Unit were able to make, it is possible to assess to some extent in what direction the control sample may be biased, and this will be discussed in Appendix III.

Despite the theoretical imperfections of the control sample it is very much better than none at all, for it provides some indication of the lives of ordinary families in the area. At any rate the use of a control group strongly suggested the unimportance of a number of hypotheses such as size of family, the position of the patient in the family, or the incidence of broken homes, which might otherwise have seemed relevant. In fact the control sample turned out to be markedly similar to the DU sample in several important respects. For instance this was the age distribution of the two samples:

Table 1 AGES OF DUODENAL ULCER PATIENTS AND CONTROLS*

	16-17	18-19	20-21	22-23	24-25	All
Ulcers	3	2	7	11	9	32
Controls	3	3	4	11	11	32

* The 2 samples were originally matched by year of birth. Since the ulcer patients had to be taken on as they were referred from the hospital, it was necessary to postpone the investigation of the Control sample. This meant that the Controls tended to be a little older than the patients with whom they were matched.

Nearly all the DU patients and their families¹ lived in three adjacent East London boroughs, which were served by the two hospitals from which these patients were drawn. Two of these boroughs are predominantly industrial in character and most of their residents are skilled or semi-skilled manual and routine white-collar workers. The families in the control sample, since they were all on the register of a single general practice, lived within a much smaller radius, mainly the older part of one of the industrial boroughs. Despite this discrepancy in geographical distribution, the occupational composition of the two samples is similar, as is shown in Tables 1 and 3.

¹ It is convenient and, it is hoped, will be acceptable, to use the following abbreviations: DU for Duodenal Ulcer; DU families for families in which the young man had DU; similarly control for control subjects and control families in which the young man was a control subject; and P.S.W. for psychiatric social worker.

FAMILY INFLUENCES AND PSYCHOSOMATIC ILLNESS

Table 2 JOBS OF YOUNG MEN AT THE TIME OF REFERRAL*

	DU	Control
A. Full-time students and trainees for executive posts in industry and commerce	6	5
B. Routine white-collar workers and shop assistants	7	4
C. Skilled manual workers in trades requiring apprenticeship or other formal training	9	12
D. Manual workers in jobs providing some opportunities for the acquisition of limited skills	4	4
E. Workers engaged in repetitive factory work, and in labouring	6	7
Total	32	32

* This classification of the young men's jobs is described in greater detail in: Logan R. F. L., and Goldberg, E. M. 'Rising Eighteen in a London Suburb', *Brit. J. Soc.*, iv, 4.

Table 3 JOBS OF FATHERS AT THE TIME OF SON'S REFERRAL*

	DU	Control
(1) Executive and small businessmen	8	6
(2) Routine white-collar workers and supervisors	6	5
(3) Skilled manual workers	10	12
(4) Other manual workers	8	8
Father not known	—	1
Total	32	32

* This classification of the fathers' jobs is abstracted from the General Register Office's scheme described in *Classification of Occupations, 1950*, H.M.S.O., 1951. Categories (1) and (4) are combinations of the G.R.O.'s Classes I and II, and IV and V respectively. Routine white-collar workers and supervisors in Class III are here shown separately (Category (2)), leaving the remainder from Class III in Category (3), skilled manual workers. If the young man's father was dead, the job classified and included in the table was his last.

Although in the first place the two samples were matched for age alone, the young men turned out to be alike not only in respect of their own and their fathers' jobs, but also with regard to their education and intelligence and to their marital status. Nine boys from each sample had won scholarships to grammar or technical schools and the results of their 'intelligence tests' (the Wechsler-Bellevue) were almost identical (see Appendix I). Twenty-three DU patients and 25 controls were single at the time of referral. The composition of their natal families can be seen from Table 4:

Table 4 COMPOSITION OF NATAL FAMILY

Size	DU	Control
1 child	8	7
2 children	5	10
3 to 4 children	13	5
5 or more children	6	10
Total	32	32
Average number of children in family	3.4	3.1
Position in family		
Subject an only child	8	7
Subject the eldest child	8	10
Subject the youngest child	4	8
Subject a 'middle' child	12	7
Total	32	32
Loss and separation of parents in childhood (Before age 15)		
Mother's death	-	2
Father's death	2	1
Parents separated	3	4
Complete families	27	25
Total	32	32

Method of Approach

The DU patients were referred by the hospitals to the psychiatrist at the Unit and during the course of his interviews he obtained the patients' permission for the P.S.W. (E.M.G.) to interview their mothers. With the controls the approach had to be different. The general practitioner introduced the research in a letter to each control subject. The P.S.W. then visited the home in order to enlist the subject's cooperation and to obtain his permission to interview his parents. Once the subject had agreed to cooperate, a similar method of working was adopted for both samples, reminiscent of current child-guidance practice. The psychiatrist studied the personalities of the patients and of the control subjects. The psychologist administered standardized tests of intelligence, 'neuroticism', and personality function.¹ The

¹ These were the Wechsler-Bellevue Intelligence tests, Crown's version of the Maudsley Word Connection Test, the Maudsley Medical Questionnaire, Murray's Thematic Apperception Test, and the Rorschach Test (see Appendix I).

P.S.W. saw the parents, and especially the mother, in order to obtain a picture of the family relationships and the personalities of the parents and a detailed history of the young man's infancy, childhood, and adolescence.

The interviews conducted by the psychiatrist and the P.S.W. alike followed a general outline, inasmuch as certain important phases in the life history of the families and the patients were explored in every case. But the interviews were kept as 'free' as possible, so that the young men and their parents could tell their stories in their own way, some guidance and interpretative comments being given when they appeared to be necessary. If either the ulcer patients and their parents, or the control subjects and their parents, presented a problem requiring therapy we tried to help. While the psychiatrist could easily adopt a therapeutic approach to the patients (who were referred to him by the hospital's gastro-enterologists) his approach to the control subjects had to be different, since the latter were not known to be suffering from any illness, and had not asked for any help from the hospital. On the contrary, they had come to provide assistance in the inquiry, and the approach had to be one of asking for information, at least in the early stages. The difference in the P.S.W.'s approaches to the two samples was less marked, since the mothers of patients and controls alike were asked in the first place to give information about their sons (Goldberg, 1953). The amount of time spent with the parents in each sample was also comparable. Families in the DU sample were visited and interviewed on an average eight times and families in the control sample seven times. The sessions lasted about two hours.

Limitations of the Case-study Method

Certain limitations are inherent in the method used in this inquiry. An intensive clinical study can of necessity only deal with a small number of individuals. At the same time the number of variables that may be aetiologically significant are many, and interrelated. The notion that a psychosomatic illness is the product of numerous interacting factors, and that it constitutes a response to stress involving the total organism, suggests that psychological factors can at best furnish only a partial explanation of the development of DU. The small number of cases that can be investigated by the

case-study method must limit the generality of any findings. However, the present investigation is based on a representative series of patients and an attempt has been made to provide a satisfactory control group. This study may thus be regarded as intermediate between the intensive study of a few selected cases and controlled studies of a large random series—which have, so far, been found impracticable. In any event an investigation of the present kind is not designed to produce definite findings of general validity. Its main purpose is to identify patterns and processes at work in the life histories of the individuals studied, so that more precise hypotheses can be stated for testing by the most suitable methods available.

In this investigation it is hoped to discover—(1) common features, or patterns, in the family background and the childhood experiences of patients in the ulcer sample, and (2) the extent to which the ulcer patients differ in these respects from the controls.

This raises the major problem of what constitutes a valid comparison. The first difficulty arises *within* each group, and it is this: although expressed attitudes and external behaviour may appear to be the same in two individuals, they may, in fact, have very different meaning and significance when seen in the context of the life situation. Or similar events in the lives of two different people may constitute quite different experiences; for example, joining the Forces would be a different experience, with a different degree of stress, for the sensitive over-protected youngster leaving a sheltered home, and for the adventurous youth who has had to 'rough it' and who may find positive support and outlets in the community life of the Forces. In order to make valid comparisons of human behaviour it is therefore necessary to study not only the social situation but also the influences, both intrapersonal and external, that may have been affecting the individual's response to the situation. Another difficulty is that in both samples the attitudes towards the present investigation varied widely from an expressed need for understanding to an almost hostile and reluctant attitude of 'giving information'. It follows that the material varied in amount, richness, emotional depth, and accuracy of facts.

Further problems of comparison arise *between* the groups. The DU patients were attending hospital because of an illness, even though few of them were aware of the possible relevance of

emotional factors in the disease. However, the patients and their families sometimes wanted help with their difficulties. For this reason they were more likely eventually to reveal difficult conflicts and painful experiences usually hidden from outsiders. This kind of information enabled the investigators to gain more insight into the underlying conflicts and attitudes within the individual and the family, and the behaviour these engendered. The control families, on the other hand, were approached because they were thought to be in some measure representative of the ordinary run of people in their district. Their conscious motives for cooperation were altruistic, to support research for the benefit of those who were ill. This attitude was bound to influence the relationships between the families and the investigators and therefore the kind of material they produced. Many might be unwilling to discuss painful experiences and difficult situations, for example their marital troubles, and it might therefore appear misleading to compare attitudes in the two groups to topics that are often highly charged with emotional significance.

However, the original differences in motivation may have had less effect on the material produced than we had at first thought. As will appear later, an appreciable number of the parents in the control sample were willing to explore their lives and attitudes in considerable detail and at some depth. For many of them this opportunity of reviewing their lives and interpersonal relationships seemed to be a rewarding experience that occasionally helped them to see events and themselves in a different perspective, or to gain insight into hitherto puzzling occurrences and relationships. In both groups there were some families with overt problems for which they wanted help. With these parents a therapeutic relationship led to the production of a great deal of rich material. The majority of families in both samples were managing their lives quite independently and had no need to turn the relationship with the P.S.W. into an overtly therapeutic one, although they discussed many problems and perplexities. A small number in both groups were only moderately cooperative and much on the defensive. Although work with these parents was found to be exceedingly difficult, the information supplied was often just as revealing as that which the more cooperative families provided. Thus, although the original motivation of the two groups may have been

different, the behaviour of the parents with the investigator, the attitudes revealed, and the material produced did not differ as greatly as might have been expected.

Besides the variability of the information provided by the two groups, there are the even trickier problems of 'observer error', and 'bias'. It has been shown repeatedly that differences of interpretation exist between highly skilled workers observing objective phenomena, for instance reading the same X-ray films, or measuring the same skulls. There is much greater risk of error in observation and of bias in interpretation of human behaviour and motivation in a situation in which the observer is himself intimately involved in the process he observes. Fuller knowledge of the interview process, and increasing insight into transference phenomena are helping us to estimate and control personal bias and to maintain objectivity. While we need to be fully aware of these dangers of involvement and bias, we are also reminded that most of the studies of observer error reported in the literature are based on single observations of isolated phenomena, whilst the case-study approach is based on a series of observations related to the whole person. Yerushalmy puts it thus: 'Repeated studies of the same case allow for integration of a number of related observations and for continuous revision of tentative diagnoses. The chance of error is thus reduced and the probability of correct diagnosis increased' (Yerushalmy, 1947).

Yet, when all is said and done, no better method than the interview at present exists which will at one and the same time provide information about the diverse activities in which people engage, and an opportunity to explore their attitudes and motives.

The use of a team approach may have helped to reduce possible errors of fact. The parents' childhood experience and background were studied by the P.S.W. only; but there are two accounts of the patient in his family, one as seen by the parents and interpreted by the P.S.W. and the other as seen by the patient and interpreted by the psychiatrist. It was the policy for the psychiatrist and the P.S.W. to work independently for a number of interviews before exchanging information at a case conference. The extent to which their information was consistent and complementary provided some check on its reliability. Reports of historical facts as taken by the psychiatrist and the P.S.W. agreed very

well in the majority of cases, and when there was a discrepancy further inquiry usually led to a correction. On the whole there was a good measure of agreement when attitudes and relationships had to be assessed, but some differences in emphasis were inevitable. Major discrepancies occurred in only a few instances, usually where divergent or contradictory reports had been made by the parents or the patient because one or both wished to conceal something. For example in two cases the patients gave what was undoubtedly the more truthful account of the unhappy relationships between the parents, whereas the mothers had not divulged this information to the P.S.W. In one case the mother was psychotic, still suffering from paranoid delusions; in the other the mother was trying to be loyal to her husband, and to hide the problem of his excessive drinking. Conversely, a DU patient had been at pains to keep his serious adolescent delinquency a secret, and it was only after the P.S.W. had known the mother for about three years that she felt secure enough to reveal the truth.

The Treatment of the Data

Before the selection of the main sample the team carried out a pilot study on 20 ulcer patients and their families, and also on 6 controls and their families. These findings were formulated into hypotheses which formed the basis of the fuller study, a part of which is being reported in this volume. In particular certain patterns of family relationships seemed to recur among the DU families. In the field work that followed these hypotheses were kept in mind, but the understanding of the particular ways in which the families and the individuals in them functioned continued to be the main concern of the team. After completing the field work I undertook a systematic examination of my interview material and that of the psychiatrist for evidence on the various hypotheses that had been formulated. In addition new notions and refinements of old ones emerged. The evidence relating to all these was then extracted in full from each case record. On this basis criteria were formulated that made it possible to compare the two samples in respect of many different aspects of family relationships and behaviour. This procedure involved several steps in compressing qualitative data, and dissecting them into small units so that they could be 'rated'. This dissection of the case material inevitably

meant that the picture of the case as a whole was lost for a while. However, a control group was set up in order to compare it with the DU group in many different respects. Only in comparing specific areas of behaviour, experiences, and attitudes did differences become apparent. When these differences were related to each other they seemed to make sense, and patterns could be seen to emerge in each group. I am very much aware that the problems of analysing and evaluating data from case studies have not been resolved in this inquiry. However, by comparing certain variables in the two samples, and by illustrating these group comparisons with individual case stories, I have tried to make an objective approach to the case material without losing sight of the inter-relatedness of specific aspects of behaviour and attitudes in actual people and families.

The following pages deal with the personality of the parents, their marriages, and then with the childhood of the patients and the controls. These observations are introduced by three detailed case studies of DU families. Finally an attempt is made to discuss the families as a whole, in terms of their functioning.

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CHAPTER II

The Families of Three Ulcer Patients

Before discussing the detailed findings of the comparisons between the family background of the DU patients and the Controls, which requires the artificial isolation of certain aspects of behaviour, it may be helpful to study in some detail the lives of three DU families.

These three families have been selected because they illustrate clearly certain types of family relationships and values that were found in some form or other in many of the DU families. Each case study is introduced by a shortened version of the first interview, which, like an overture, usually contains the main family themes. Thereafter the stories are presented in historical sequence, drawing on all relevant interview material obtained by the psychiatrist and the P.S.W.¹

It is realized that these stories merely tell us something about how the mothers and fathers of the young patients saw themselves and their experiences, and their comments may not always correspond with reality. Although it is clearly desirable to know what actually happened, in retrospective studies we sometimes have to remain content with this kind of 'psychological reality'. However, the interview material can reveal much about the personalities, the motives, and the ideals of the informants. While one cannot always be sure about the facts, it is possible to learn how the individuals have seen and dealt with various situations in which they have been involved.

¹ My interviews were written up in note form immediately after the session and later typed. Since no verbatim records were made during the interviews very little of the material is direct quotation and much of it had to be compressed for purposes of presentation.

OVER-INDULGENCE—THE ALLEN FAMILY

Mrs Allen was first seen after her son Derek, aged 16, had been admitted to the hospital with haematemesis. Young and girlish-looking for her age, talkative and confiding in her manner, she seemed an intelligent and very active woman who professed to have no patience with people who do not work hard. Warm and friendly feelings flowed from her to the P.S.W. Her opening remarks were, 'He is terribly nervous, nervous of his bedroom. He looks under the bed and through the window and locks himself in every night.' Mrs Allen then went on to describe how sensitive Derek was and how thoughtful; how he remembered her wedding anniversary the other day, and bought her a bottle of perfume. 'He has such nice ways with him, you feel you *must* do things for him.' She described how she had his tea ready and his clothes put out when he came home in a rush from work. 'My husband says I spoil him, but he hasn't time to do these things for himself.' Throughout the interview she apologized for 'spoiling' him, although no criticism was offered. She mentioned that she was always buying things for him, for instance a new shirt, which she had brought along for him to see while he was in hospital.

Mrs Allen then recounted how active Derek was, going to the Youth Club every night, coming home about 10.30 p.m. when his father had usually gone up to bed; how he liked his mother to wait up and keep him company during his supper; when he would tell her of the evening's happenings, and how he would finish up by saying good-night about four times. She praised Derek for being a very good worker, and reported that his employer called him one of the best among his juveniles. He was like her own father, a tremendous worker of quick intelligence who had excelled in his trade from an early age; built up a business of his own, and had finally 'worked himself to death'.

On likening Derek to her own father, Mrs Allen added, 'I must not say this in front of my husband.' Derek's father, a carpenter who was 'always making things for the home', was mentioned less than the maternal grandfather. He was said to 'adore' Derek, and still put hot-water bottles in his bed every night. Derek's sister

aged 10, was also reported to admire him and to be looking forward eagerly to his discharge from hospital. Mrs Allen felt that Derek was driving himself hard, and not getting sufficient rest, which she thought might be partly responsible for his ulcer. However, she sympathized with his zest for living, and quoted with approval his saying: 'I'm young, I want to have lots of fun.' On Saturday and Sunday mornings she gave him breakfast in bed to induce him to rest. Derek worked in a factory, but Mrs Allen really wanted him to become a clerk, 'something nice and clean', which she thought more suitable for him.

Mrs Allen's Personality and Background

Mrs Allen was an intelligent woman, in her early forties with a friendly, open approach to the world. She had many friends to whom she was always ready to lend a helping hand and she enjoyed looking after her family. She was capable of much energy and drive, and insisted on keeping her part-time job, although conditions at work were unpleasant, and she herself mentioned that there was no economic necessity for her to do so. She was very keen on housework and cooking and had a passion for polishing. During an illness she became depressed and upset as she was unable to do her routine cleaning. However, she never interfered with her family's comfort by nagging fussiness. Her home-making qualities found their fullest expression when she obtained a Council house. Both parents went to infinite trouble to improve it in every respect, and the mother discussed at great length how much satisfaction she derived from polishing the paintwork. Mrs Allen also liked 'fun' and meeting people. The main attraction of her part-time job was the opportunity it provided to meet people and she enjoyed parties with adolescent eagerness. She liked to be independent, and was critical of people who did not help themselves. Although major decisions were discussed with Mr Allen, Mrs Allen planned and decided the main activities of the family.

Mrs Allen grew up in Dundee, an only girl among several boys, in comfortable material circumstances. She often stressed in her interviews that material things were not the most important and that she felt she had been deprived of what she considered essential in a young person's life—freedom, social contacts, 'fun', and

'peace of mind'. Her father was a successful man with great initiative, who left his home-town as a young man and built up his own business without capital or help. She often stressed with evident pleasure his intelligence, his hard work, his zest for life and enjoyment—he went out a great deal and every minute of his week-end was booked up. She often compared Derek with him in these respects and contrasted her husband's achievements with her father's. Later she expressed some criticism of her father's selfishness and lack of consideration for others. He expected her to look after the house and the family and to nurse her bedridden mother. She was never able to go out to work like other girls and he laid down strict rules about her coming in at night, while he went out and enjoyed himself. When she watched other girls going out to work she became resentful and envious and gradually started to argue with her father. These differences culminated in painful scenes during her courtship, which she still remembered vividly. To this day she enjoys the feeling of coming home after a visit to the cinema without fear of an argument. She often expressed her determination that Derek should have the pleasures she missed, and went out of her way to be friendly and warm to him when he came in, chatting to him about his activities. Her father was devoted to her, as she to him, but he had hoped that she would look after him indefinitely. Even after her marriage, and during her pregnancies, he expected her to run his house. Mrs Allen blamed him indirectly for the death of one of her babies whose premature birth she thought might have been due to the heavy work entailed in nursing her mother. 'He used me as a cheap housekeeper.' On the other hand when her husband criticized her father and pointed out how selfish he had been, Mrs Allen became irritated and defended her father. In spite of the difficulties he had created she admired and loved him fiercely and often wished that he were alive so that she could turn to him for advice.

Mrs Allen talked comparatively little about her mother and her feelings about her remained obscure, except for occasional expressions of mild resentment that her nursing duties should have been taken so much for granted. She had been bedridden with arthritis since Mrs Allen was a child. Mrs Allen described her as both a patient, generous woman and as a selfish one, because she expected her daughter to devote herself wholeheartedly to looking



after the family. She died when Mrs Allen was 28, her husband two years later. Since then Mrs Allen has had little to do with her brothers in Scotland.

Mr Allen's Background

Mr Allen came from the same town as Mrs Allen. He was the eldest of seven and remembered his childhood as an unhappy time. He had suffered from being the eldest and had felt pushed into the corner. He did not remember ever having any toys and vowed that he would give his children the happiness he did not have. His father was an enterprising man who left Scotland during the depression and on coming South started a small business of his own in which he was successful. He was described as a nice, gentle man, generous to his family, popular, and known everywhere as 'Pop'. The paternal grandmother was described as a moody jealous person, ungenerous to her children and rejecting towards Mr Allen. She was said to be the boss of the family, her husband keeping quiet for the sake of peace.

On leaving school, Mr Allen followed the family tradition of carpentry, until the depression when he was out of work for three years.

Following the lead of his family he came South in the thirties and started to work in his father's business as a carpenter. Later he went to work in a factory where he became a chargehand. He was very conscientious about his work and put in a great deal of overtime. He was called up in 1942, and while he was in the Services 'saw many terrible sights' which upset and depressed him. Since leaving the Forces he has suffered from heartburn and also from feelings of flatulence and fullness after meals. He has had no medical treatment for this.

His wife and son described Mr Allen as a quiet 'stay-at-home' who did not like going out very much but devoted a good deal of his spare time to decorating the home. He put much effort and craftsmanship into improving a new Council house, which the housing authorities have shown to other people as an example. Gardening and, recently, television were his only other hobbies. He seemed an anxious man with a worried expression and a distinct hesitation in his speech, eager to discuss with the P.S.W. whether he was in any way to blame for his son's illness. When

the P.S.W. visited the house he usually effaced himself, as though still relegating himself to his childhood corner.

Marriage

Mr and Mrs Allen first met during the depression, when she was in her teens. Mrs Allen had originally been attracted to his friend, a much more dashing young man, who however, chose her girl friend. Mr Allen was a patient rather silent suitor. He persisted in his efforts despite great opposition from Mrs Allen's father, who pointed out that Mr Allen would be unable to keep his daughter in the comfort she was used to, and regarded him as socially inferior. Mrs Allen twice tried to break off the engagement, but Mr Allen continued to court her. Eventually his persistence and his misfortunes aroused her sense of loyalty and protectiveness and made her determined to marry him. They married when she was 20 and he 23, and spent the first five years of their married life in the maternal grandparents' house in Scotland, living, rent free, on his very small unemployment benefit, while Mrs Allen continued to keep house for her parents and brothers.

Despite her father's criticisms of her husband and her awareness of her father's jealousy, Mrs Allen felt that the marriage was a rewarding and satisfying one. Mr Allen shared these feelings since his wife brought him warm affection and a certain protectiveness and optimism, being a great contrast in some respects to his own mother. The marriage has remained a warm, intimate one, Mrs Allen being on the whole the leader and initiator. They have always been able to talk over their differences and their worries about the children. The only important point of disagreement between them is that Mr Allen likes his fireside, while Mrs Allen has remained eager to go out and make friends. They have come to accept their different outlooks without any bitterness, each appreciating to some extent the reasons for the other's different needs. Mrs Allen realized that her husband's deprived childhood had led him to value his cosy fireside above all else and Mr Allen knew that his wife's eagerness for fun and sociability had its roots in her adolescent frustrations. Mrs Allen stressed that her husband was an interesting companion, despite his quietness, and one who knew a good deal about many different things.

The Allens' Children

The first child was born prematurely a year after marriage and lived for only a few hours. Mrs Allen was very upset and at first refused to be parted from her dead baby. She resolved not to have any more children, but a year later a second son was born. He developed pneumonia and, despite devoted nursing by both parents, died at the age of 5 months. Mrs Allen revealed these losses rather late in her contact with the Unit and expressed much feeling about them. During her third pregnancy she fervently wished for a girl. She had always felt the burden of being the only girl among brothers, and she now had a growing conviction that male babies were bound to die. When told of Derek's sex, she would not look at him for the first day. The father on the other hand was elated when Derek was born. During the first year of his life Mrs Allen was haunted by the fear that he might die. She would not allow herself or anybody else to make a fuss of him, and it took her a long time to become reconciled to the idea of his being a boy.

Mrs Allen breast-fed Derek for seven months with difficulty and she felt very exhausted during this time. However, Derek was described as a contented baby. He was 'potted' on the mother's knee from the age of 3 months and Mrs Allen did not recall any difficulties over toilet training. When he was one year old the family moved South. Mrs Allen hoped to achieve a certain measure of freedom at last but again she had to live with parents, and once more she was tied to the home, helping her mother-in-law in her business. When he was two Derek was sent to a day nursery. In the evenings when he was lively, he wanted to play with his mother, and she with him, but the grandparents found him a nuisance and urged her to put him to bed early. Mrs Allen related how this situation aroused conflicts of loyalty. At the day nursery, Derek was described as a very well-behaved, cooperative child, who never gave any trouble. A report from the infants' school later on said that he used to be very backward and gave the impression at all times of being 'a ship without a rudder, and no skipper in the person of a parent who was able to control his activities'.¹ When Derek was 6 years old his sister Denise was

¹ An attempt was made to obtain school reports on the boys' achievements, general attitudes, and behaviour and their relations with other children and teachers from all the

born. Mrs Allen described that day as the happiest of her life. Derek is reported to have been jealous of the baby and to have clung to his mother. Shortly after Denise's birth the War broke out and he was evacuated with his school for three years. Mrs Allen brought him home in 1942 because she had had reports that he looked neglected. In the same year Mr Allen was called up. This upset Derek very much and he cried for his Dad, went off his food, and talked incessantly about his return. After about a month this acute distress subsided but he missed his father badly throughout his absence. The relationship between Derek and his father seems to have been very close during the first six years of his life as Mr Allen used to take Derek about with him whenever he could. Later Derek had two further short periods of evacuation in foster homes where he was unhappy, and during the flying-bomb attacks he was evacuated for the fourth time. He was well looked after but wrote fretful letters to his mother, begging to be taken home. Mrs Allen went to see him, heard him crying in bed during the night and took him home. There is a certain amount of confusion in both the mother's and Derek's mind about the evacuation period, and some discrepancy between the two accounts.

Derek's health was good in infancy and early childhood. After measles at the age of 4½, he had frequent coughs and colds which later developed into asthmatic attacks. On his return from evacuation his attacks became severe and he attended hospital for two years. Unable to join in active games, he became more dependent on his mother, who often sat up with him during the night when he had his attacks. He improved rapidly after his father's return from the Forces in 1946.

Both parents described Derek as a well-behaved cooperative child, who 'never gave any trouble'. He always watched his sister rather jealously in case she got a bigger share of the good things in life, but his mother maintained that Derek always had more than Denise. He shared a bedroom with his sister until he was 18 years old. She reported that he was always looking under his bed and often woke her up on some pretext or other because he was

schools they attended. Little information could be gained from infant or junior schools, but useful reports were obtained for over half the bus and controls from the senior, grammar, or technical schools.

frightened. He always had 'loads of friends' but rarely seemed to take the initiative among them. At school his achievements were reported to be below average, and he did not win a scholarship to a grammar school!

Mr Allen wanted Derek to become a skilled worker, and on leaving school he started at an engineering firm with a view to an apprenticeship. Derek, however, disliked evening classes and the small wage. He refused to sign the apprenticeship indentures and much against the wishes of his father found himself a semi-skilled job. His mother would have liked him to have a neat and clean occupation, as a clerk, for instance; but she did not mind his changing jobs as long as he was happy and working regularly.

Derek's dependence on his mother, which had developed during his asthmatic phase, continued side by side with signs of emancipation. He changed his jobs frequently to suit his ideas of freedom and independence. He decided eventually to take up driving. At the same time, he preferred his employment to be nearby so that he could come home to his midday meal. He joined in all kinds of adolescent group activities and a rowdy gang life, but expected his mother to put his clothes out for him and to sit up for him at night. He wore draped suits and had his hair cut in the latest style. On one occasion he stayed away from home all night with his friends. Although his parents did not like his activities and affectations they acquiesced, and he always managed to get what he wanted from them. This pattern persisted into late adolescence. At the age of 19, he suddenly decided to marry, relying on his parents to make the arrangements for the wedding, and then happily settling down to a continuation of his accustomed family life with his mother looking after both him and his wife.

Denise grew up into a healthy 'tomboyish' girl, with many friends. She remained with her mother throughout the war and never went to a day nursery.

Family Relationships

Mrs Allen gave a frank account of her initial rejection of Derek and of her difficulties in developing positive feelings towards him. These she related to her fear that he, like his brothers before him, might die. There were feelings of conflict when she had to send

him to the day nursery because she felt that she needed to work in order to build up a home after her husband's long unemployment. The father on the other hand was thrilled at Derek's birth and did much for him, especially while he was still out of work. Derek's depression when his father joined up indicates the intensity of the bond between them. Derek's prolonged evacuation constituted a further break in his relationship with his mother and the discrepancies in their accounts—the mother reporting more frequent visiting than Derek—may reflect a feeling of unease in the mother about this prolonged separation. During adolescence the indulgent character of the mother-son relationship and the mother's identification with Derek's thirst for pleasure became evident. Mrs Allen enjoyed recounting how she bought presents and clothes for Derek, and how much more he got than Denise. She also mentioned repeatedly how she always had Derek's meals ready for him and his clothes laid out. After many interviews she related how she waited up for him at night, airing his pyjamas in front of the fire with his hot drink ready on the stove. Yet she often complained about his late nights and protested in an unconvincing manner that he ought to stay in more. She was unable to exert any decisive influence over his activities and she found it difficult to deny him anything he wanted, whether it was money, outings, or bicycle rides—which were forbidden by the doctor. Later, she gave in to his sudden desire to marry at the age of 19 without any money or plans for an independent life. She solved the problem of this marriage by regarding her daughter-in-law, a girl of 18, as an additional child in the family whom she could 'mother' and indulge. She related with pride how the girl was thriving under her care, having been deprived in her own home. Mrs Allen chose the young couple's bedroom suite, planned and gave the reception, and, after their marriage, cooked and did the housekeeping for them.

As Derek was hardly ever at home in adolescence the father saw very little of his son after his own return from the Forces. He considered it a great treat when Derek stayed in and talked to him, and made many attempts to entice him to remain at home in the evenings, the final bait being a television set. However, Derek responded very little to these overtures and used to override his decisions with ease, when he changed his jobs for instance. On the

other hand, he would consult his mother on whether to leave a job. Having got her permission he would get her to talk his father round. Although Mr Allen was so devoted to Derek there was also evidence of some jealousy. When the mother laid the clothes out for him, Mr Allen would say to her, 'You never did this kind of thing for me.' Whereas Mrs Allen in her heart sympathized with Derek's ambition to have 'lots of fun', the father was critical of this tendency and 'nagged' more than the mother.

The mother appeared to be the stronger personality and the leading influence in the home. Although matters were nominally referred to the father, the mother in fact made the decisions, for example about buying a television set, consenting to Derek's leaving his job, and deciding on their holiday plans.

Denise has always been said to 'admire' Derek. When he married she voluntarily gave up her bedroom for the young couple. Derek's jealousy of Denise in time gave way to a somewhat censorious attitude; he admonished and criticized her a great deal when she went through a stage of tom-boyish wildness and impressed upon her the need to be clean and ladylike. When she sat for her scholarship he was full of good advice.

All the members stressed the cooperative aspect of their family life. The mother said how fond they were of each other and mentioned as examples the father putting the hot-water bottle in Derek's bed, her sitting up for Derek, Denise insisting on staying up for her father, and Derek remembering her wedding anniversary. Derek stressed that in his family they 'never argue, but only discuss'. There was little friction. Negative feelings were expressed on rare occasions, for instance when Derek chose a heavy job in engineering against his parents' express wishes. Even then there was ready acquiescence under the family slogan 'as long as you are happy, that is the most important thing'. The home was a cheerful sociable one. Neighbours were welcome, and there were joint outings and parties with the paternal relatives who lived nearby.

Both parents came from families in which the fathers had built up businesses of their own. Both parents were hard and conscientious workers, and laid emphasis on the achievement of reasonable standards of behaviour. Their aspirations for their children were modest. The father stressed the importance of learning a skilled

trade which was obviously linked to his own unemployment. The mother stressed sociability, neatness and tidiness, wanting Derek to be a clerk and Denise a dressmaker.

Both parents showed much indulgence towards their children, and particularly towards Derek. This attitude can be understood in terms of their own childhood deprivation for which they were compensating in their relations with their children. The mother was still hankering after the 'fun' and excitement she did not get as a young girl and was obtaining gratification through Derek's activities. The father was also finding satisfaction in giving to his children the things he never had in his own childhood. The parents' indulgence may also have resulted in part from negative feelings. The mother may be making reparation to Derek for her initial rejection, the father for a feeling of rivalry and jealousy.

AMBITION AND RESTRICTIVENESS—THE BROWN FAMILY

Mrs Brown was first seen in her home when her son Peter was attending the Out-Patient Department after an operation for perforated ulcer. She was getting on in years and her face was carefully made up. The home conveyed a middle-class atmosphere. It was tastefully decorated, the walls, carpets, and curtains were immaculate and great care seemed to be expended in looking after the house. Mrs Brown indicated that she had lived in comfortable circumstances all her life. She described herself as quick-tempered and nervous, and soon discussed her sick headaches saying that they occurred whenever a situation became too difficult for her to cope with and she wanted to escape from it. She also saw herself as a great worrier, as someone who was very devoted to housework and one who always found something to do.

She mentioned almost immediately how much she missed her mother who had lived with her since her early married days and who had recently died. Her mother had been a very forceful woman who had said 'I won't interfere' but who had, nevertheless, exercised much influence in the household. She had suffered from a crippling disease and became quite helpless through the years and increasingly dependent on Mrs Brown. Although the

maternal grandmother became a heavy burden, the mother had valued her presence; she had been able to confide in her and, in this way, get rid of her resentment and discontent about her family. During the last years the nursing care of her mother became too much for Mrs Brown and the old lady had to be admitted to hospital. Although she used to visit her mother three or four times a week she could not help feeling guilty at letting her go to hospital. Now, while missing her mother badly, she also enjoyed her newly gained freedom. Mrs Brown also talked about a younger sister who had died of tuberculosis, a bohemian type, good-looking and fascinating, who lived an interesting life in Italy as a painter, and pitied Mrs Brown for her dreary, tied, bourgeois existence.

Eventually Mr Brown was mentioned. He turned out to be a buyer who had worked for the same concern for many years. Mrs Brown described him as a very quiet man, in contrast to herself, and less actively concerned about Peter's career than she was, if not actually somewhat indifferent. The mother's main worry about Peter was his lack of ambition. Peter had matriculated with several credits but he had not done well in his subsequent studies. After his return from the R.A.F. he obtained a routine office job of which the mother did not approve at all. She wanted him to be articled to a solicitor, but he was anxious to earn a good wage on leaving the Forces, and would not consider a long legal training. Under his mother's pressure, he agreed to go to evening classes three times a week, but she knew that he did not really want to go and that he resented her ambitious drives. Recently he had joined an amateur orchestra and was devoting so much time to rehearsals that he had had to postpone his examination. The mother was in great conflict about this situation, as she recognized that his musical activities had brought him out socially. Was it right, or of any use, to push him? Mrs Brown realized that he had an active mind and wide interests, but felt that he was quiet and reserved like his father, and she feared that unless someone pushed him he, like his father, would be content to drift into a rut. Pauline, seven years younger than Peter, was a great contrast to him. She was 'outspoken like I am'. Mrs Brown's parting words were, 'Could you see that the doctor kindles some ambition in my son?'

Mrs Brown's Background

Mrs Brown was the eldest of three girls and one boy, the children of the manager of a small steel factory in Sheffield. She admired her father for his hard-working qualities, his close relationships with his workmen, and the good example he set them. She held the same political views as her father, having started her apprenticeship in politics by canvassing for him. He died when she was in her teens. The maternal grandmother was described as a very capable, domineering, and forceful person who struggled hard to bring up her children after her husband's death. She became increasingly crippled and Mrs Brown bore the brunt of this illness throughout. The maternal grandmother expected Mrs Brown to consider her needs first, and it had never occurred to the latter to refuse when her mother asked if she could make her home with her soon after her marriage. Mrs Brown described both her sisters as being much more beautiful than herself. One of these, the painter, was selfish and inconsiderate. She did not share the task of caring for the maternal grandmother, and imposed on the mother by bringing friends home for her to wait on. Later, while living abroad, she descended on her for holidays and she also relied on Mrs Brown to nurse her during her last illness, when she was already nursing the maternal grandmother. Mrs Brown described her youngest sister as exceptionally sweet-natured, but she had died at the age of 20. Her brother had left home early and she had completely lost touch with him.

The outstanding characteristic of Mrs Brown was her critical and driving attitude. She was hard in her criticisms of husband and children, but equally exacting with herself. Indeed, she seemed almost merciless in her self-criticism. She felt herself to be a nagging, unpleasant person, who was always 'on at her family' and never satisfied. Mrs Brown was frank in her admission that she did not like children, a theme which she pursued in many ways. Other people, she felt, only praised their children and thought they were wonderful, whereas she could often see the faults of hers and would compare them unfavourably with other people's children. She questioned whether she made her children into problems, and often wondered whether she had done any harm by pushing them so hard. She had postponed motherhood for five years after

marriage. Peter was a planned baby, but she really wanted a girl. During her pregnancy with Peter's sister, which occurred seven years later, she cried for nine months, feeling that 'this was the end of her youth'. She stressed that her babies were not nursed or played with, and that she and her husband followed a strict routine. She thought that she had been short-tempered and impatient as a mother, finding it easier, for example, to dress the children than to let them dress themselves. Peter told the psychiatrist of many hidings he received from his mother, and Mrs Brown remembered with guilt spanking Peter hard when he came home from school late and muddy.

Mrs Brown ran her home with great efficiency and she held that mothers should look after their children, cook their meals, not rely on school canteens, and in no circumstances go out to work. Yet she had wanted to go out to work herself, though her husband had not allowed this. She was inclined to wait on her children and do a great deal for them, but resented their dependence on her and their need for protection, which she felt were like a continuation of her endless nursing of her mother and sister. She could not derive satisfaction from her dutiful nursing, since she had done it grudgingly and resentfully, not willingly and with love as her youngest sister would have done.

Mrs Brown clung to her youth, was most reluctant to reveal her age, and envied her second sister who had seen the world, and had found the pleasure in life that seemed to elude her. Her irritation with her family came out most clearly during holidays, when they were all at home. She complained about the eternal round of cooking, of people always wanting things from her, and felt depressed and hopeless. Her defence against this depression was an incessant round of housework. She had to work strictly to a programme, preferably keeping ahead of her schedule. She expected the same kind of dutiful activity from her children, and constantly admonished them about homework and other duties. As Peter expressed it, 'Mother is always pressing me from behind.' At the same time Mrs Brown felt that her continual criticism and nagging had done harm to her children, and she tried to find ways of reaching them that would prove to her that she was after all a good mother. In spite of the tension between them, she felt that Peter was very close to her, and was suffering like herself from a

habit of sitting down under things and from an inability to assert himself, although deep down he might resent the situation. During her talks, Mrs Brown became dimly aware how she had been unable to assert herself *vis-à-vis* her mother, and that her son in turn was wrestling with a similar problem.

Mr Brown's Background and Personality

Information about Mr Brown's background and personality was gained indirectly, from the mother and Peter, as he refused to see the P.S.W. He came from a middle-class business family in Sheffield. His parents had died some time before and his married brothers were living in the North, so there was hardly any contact between the Browns and the paternal family.

Mr Brown had been working for a large concern for many years. He was very interested in his job, which was varied, and had been promoted to buyer. He had not, however, achieved an executive position as his wife thought he could have done with a little more drive and ambition. Mr Brown, on the other hand, appeared to be satisfied with his position and talked about 'giving young people a chance to rise'. Both Mrs Brown and Peter described him as a very quiet person, in contrast to his talkative wife. He read a great deal, though his main hobby was gardening. He was extremely neat and methodical, and had no desire to go out in the evenings or at the week-ends, or to travel and gain new experiences on his holidays. In the home he left everything to the mother and usually fell in with her plans 'for the sake of peace'. However, he did not follow her suggestion to come and see the P.S.W., which Mrs Brown said was the only point-blank refusal she ever experienced. He felt that his wife and Peter had already revealed too much.

Mr Brown had always been fit; he had some slight chest trouble during the War and was off work for six weeks. Subsequently he took great care whenever he had a cold. The mother realized that on these occasions he wanted to be looked after and to have her sympathy, which however she was unable to give him, feeling that he made 'far too much fuss'. The mother reported that Mr Brown was very interested in Peter as a baby and had definite views on baby routine. He did not believe in picking infants up and insisted on letting him cry. He was strict on the child getting

to bed at certain hours and took an active part in his toilet training. In fact, when Peter was small, the father 'could not do enough for him'. When the younger sister was born, he transferred his interest to her, and Peter felt that he was more generous to her than he had ever been to him. He never gave Peter any active guidance about his school work or career, nor did he take him out or encourage him in games. Indeed, Peter remarked that he had never had a real talk with his father about anything, and that he knew very little about him. Mr Brown seemed proud of his son's intelligence, but rather critical of him, for instance when Peter helped with any odd jobs in the house. He had very little direct contact with Peter, usually conveying his requests through the mother; and he was far less concerned about Peter's lack of progress in his job than was his ambitious mother.

The impression that mother and son gave of the father was of a very intelligent man who in his early married days had displayed some leadership and initiative in the home. The mother had definitely followed his lead regarding living arrangements and general routine. Gradually he appeared to have given in to the needs of a driving and very active wife and of a difficult and invalid mother-in-law who absorbed a great deal of his wife's attention. His means of coping with this situation seems to have been withdrawal. One also gets a hint that this father harboured some jealousy of his son and resented the close relationship between son and mother. For instance, he did not like Peter staying in bed on Sunday morning and the mother taking his breakfast up to him.

Marriage

We know little about Mrs Brown's courtship, except that in her youth she had been in love with someone else who had rejected her. During their young days, both the father and the mother had a desire to fit in with each other's interests. However, soon after their marriage the maternal grandmother came to live with them, and throughout the ensuing years Mrs Brown was preoccupied with the increasing burdens of an invalid mother and sister to the detriment of the marital relationship. The husband resented the presence of his mother-in-law. The maternal grandmother felt greatly hurt when Mrs Brown announced that she was having a

second child, since Mrs Brown would then have less time to devote to her—a situation that gives some inkling of the rivalry between Mr Brown and his mother-in-law.

Mr and Mrs Brown developed in opposite directions until they had very few ideas in common. She liked straight plays on the wireless, whereas he liked musicals. He appreciated quiet; she liked to chat. During his holidays he loved to potter in his garden, whereas she wanted to travel abroad. Mrs Brown had to get on with things straight away, but Mr Brown was for ever procrastinating. Although Mrs Brown was satisfied with her husband's status at his firm, she would have liked him to reach the executive grade, and criticized his being satisfied to remain in a rut. They were both aware of their opposite tastes and tacitly decided to go their own ways. There was little communication between them. Mrs Brown felt that if she did not prattle away in the evenings they would sit in silence. Problems were rarely talked over, and neither seemed prepared to fulfil the role the other wished him to play. For example, when the father had a cold and wanted a little fuss and mothering, the mother was unable to give it to him. In fact Mrs Brown envied her single sister and conceived of the feminine role as one of endless drudgery. If the mother was ill and the father did his best to look after the house and to get the family's meals, she was irritated and distrustful, getting up secretly to inspect and do things over again and feeling nothing but exasperation with her husband's well intended efforts. There was, however, an indefinable bond between them. Mrs Brown respected her husband's outstanding intelligence and fairness; and according to her they enjoyed their sexual life together.

Peter felt that his parents got on well on the whole, but quarrelled over 'little things'; his mother would nearly provoke an argument, and then his father 'would sit there and not say a word', though occasionally he lost his temper.

The Browns' Children

From the very beginning Peter and Pauline had contrasting experiences and personalities. Whereas Mrs Brown was well during her pregnancy with Peter, she was very sick and unhappy during her pregnancy with Pauline seven years later. Both were partially breast fed. Peter was slow and lazy at the breast, and remained

indifferent to food and a very slow eater until puberty. Sometimes he would take two hours over his dinner. He did not even show enthusiasm over sweets, they would lie in his drawer untouched for months. Pauline, on the other hand, fed lustily and has remained very interested in food. She was fat, whereas Peter was lean. From birth both were put on the pot after every feed and early in the morning. Peter was easily trained to cleanliness, Pauline was still wetting the bed when she was 12 years old.

Peter was a compliant and quiet child, the mother added 'perhaps too compliant', but Pauline had temper tantrums as a small child, banging her head against the wall when she could not get what she wanted. Peter would accept authority without question; for instance he would do his homework promptly and go to bed without a murmur at his set time. Pauline always found excuses for not doing her homework until late in the evening and would argue interminably about going to bed. Peter was a solitary child living in a world of fantasy, frequently talking to himself. He never showed his feelings and would not cry or say 'sorry', or kiss his mother spontaneously. Once when his mother accused him of not having any feelings he retorted that he did feel things but could not express them. Pauline on the other hand was a most friendly child who even in her pram smiled at every passer-by. She knew all the neighbours, whereas Peter did not recognize them. Pauline was said to be sensitive, she got upset easily and cried readily, but after an upset would soon kiss her mother, apologize, and then forget all about it. Although Peter never showed any open rebellion, his mother felt that he often nursed a resentment underneath, and occasionally he could be stubborn. Despite his reported good behaviour he received many smacks from his impatient mother, and he was adored by his maternal grandmother who lived with them until he was grown up. Peter always avoided fights and his pursuits were solitary. He played in the garden, went on cycle rides, and read widely. When his mother was pregnant with Pauline he got worried about her fatness and implored her to eat less. She then told him that 'a baby was growing under her heart'. He liked the baby but the gap between them was too great for any companionship. Later he often complained that Pauline was allowed to have more of her own way and enjoyed more privileges than he ever did. When Pauline was about

a year old both the grandmother and the maternal aunt became very ill and required much nursing care, and Peter had to give up his bedroom. Mrs Brown wondered whether these experiences coming so soon after Pauline's birth helped to 'put his nose out of joint'. This was actually confirmed in Peter's interviews with the psychiatrist, in which he talked about his feelings of rejection and loneliness when he was sent out to play because his mother was so busy.

Soon after these events the whole family, except the aunt, evacuated to Exeter, and Peter was sent to a local grammar school. He had previously attended a private school, where he seemed happy and had made good progress. At the grammar school he became very unhappy and cried a good deal. He seemed unable to adjust to the big mixed school and began to play truant. Both Peter and Mrs Brown mentioned how different he seemed from the other boys with his polite and timid manners. His school report states that he was good at his work, did not show any interest in games, and was a troublesome pupil in a 'pert, impudent way'. The other children bullied him and he made no friends. The teaching staff felt that he had a tendency to provoke antagonism from his fellow pupils. During this period it was found that one of his testicles was undescended and he was taken to the doctor. Mrs Brown thought that he worried about this and that he was also concerned about sexual problems. She had always been open and natural about sexual matters, and she was somewhat puzzled about Peter's shyness with girls. As Peter was not settling down at the grammar school his parents eventually transferred him to a private school where he was happier and did well in the General School Certificate Examination, although he never sat for the Higher School Certificate.

His full-scale I.Q. was found to be 131 on the Wechsler test (i.e. the top percentile rank), which suggests that his school performance never approached his actual capacity, and this although he always did his homework conscientiously. On leaving school he studied engineering, a subject at which he failed in two different colleges.

Pauline also attended a private school and was doing reasonably well, though her intelligence was only around average. However, she too experienced great difficulties in her relations with other

children, as they teased her about her fatness, which made her particularly awkward at games. As her bed-wetting stopped, so she began to develop asthma. Peter was a healthy child on the whole though in his early puberty he used to have periodic high temperatures for a day or two, which remained undiagnosed.

Family Relationships

The Brown family lived in pleasant material circumstances, each member doing his or her duty conscientiously. No major upsets occurred and their neighbours would not hear any raised voices. Yet beneath this surface of solid unity and despite the indications of their affection and concern for each other, there were many tensions and frustrations which divided the members of the family. None seemed able to fulfil the roles which the other members in the family expected of them. This gap between expectation and fulfilment was most evident in the mother, who said that she was always discontented and wanting to be 'higher up'. Her restless discontent caused her husband and children to feel somewhat hopeless about their ability to fulfil her expectations of them.

Peter realized that some of his mother's demands were quite justified and he felt he should be more helpful and cooperative, yet time and again his obstinacy drove him to frustrate her. Mrs Brown was always anxious to find out what he was doing and feeling, but Peter did not tell. He would postpone indefinitely things that he knew she wanted him to get on with. She could hardly bear her frustration at his lack of ambition, which was all the more infuriating in view of his excellent intelligence. Peter on the other hand felt that his mother was 'all work and no play'. He had a feeling of hopelessness about himself which seemed to stifle his efforts and add to his failures. Similarly Mrs Brown was somewhat disappointed in her husband and his lack of thrust and initiative.

Pauline, with her outgoing temperament, seemed to be reaching for affection from both mother and father with greater freedom than Peter. However, she too revealed a good deal of unhappiness and insecurity when, at the mother's request, she was seen by the psychiatrist. In her bed-wetting and asthmatic attacks she seemed to go back to the stage of babyhood, when she could

command her mother's attention. She was not as hopeless about herself as her brother, but tried to live up to her parents' expectations of her, intending to go on to the university, although it was doubtful whether she was intelligent enough for an academic career.

Thus everyone in this family seemed to harbour disappointments, which they could not discuss openly and for which they sought solutions in different ways. The impression was conveyed of everyone pulling in different directions. There were no outings or games in which the family joined together. There was little conversation at the dinner table, although this was an intelligent and articulate family. However, it was possible to observe that as mother and children gained some insight into their conflicting strivings and frustrations, so the tensions in the family decreased and so they were able to release some of their positive feelings for each other.

ANXIOUS PROTECTIVENESS—THE COHEN FAMILY

Mrs Cohen, a Jewess, was in her forties when her sixteen-year-old son Michael was found to have a duodenal ulcer. The interview took place in the dining-room of her house, which was quite elaborately furnished. She was small, rotund, with dark pleading eyes, and spoke freely in a highly emotional manner. Occasionally she broke down in tears, accusing herself of failure in bringing up her son, and stressing the ordeal of having to reveal this failure to a stranger. She was much exercised by Michael's persistent lateness, and his indifferent performance at work, which she was afraid would lose him the job that offered him such a wonderful chance. No matter what she did for him or how pleasant an evening the family spent together, he would be late for work the next morning. She described his lateness as though it was a personal attack on her. One morning she was so upset that her legs gave way. This startled him but he still persisted in being late.

Michael was self-conscious and shy, had hardly any friends, and preferred to go out with his parents, who felt that he should be with young friends of his own. The mother had suggested various friends from the Synagogue, but Michael was not interested. If he was asked to do anything he would never say 'no' outright,

FAMILY INFLUENCES AND PSYCHOSOMATIC ILLNESS

but would always try to postpone it, a manoeuvre that Mrs Cohen called 'passive resistance'. She also described her disappointment over Michael's lack of progress at school, which was all the greater as she felt sure that he was intelligent. Not being satisfied with the teaching Michael received during evacuation, she achieved his transfer to another school where he worked hard for, and obtained, a scholarship. At the grammar school he did not do his homework and changed his subjects several times. As there was no chance of his matriculating, he was allowed to leave before he was 16, and this had been a great blow to Mrs Cohen. She related what a nice obedient boy Michael had been up to the age of 5 or 6, a period that coincided with the birth of his brother and the family's evacuation. Soon after these events difficulties started. Michael would spend hours in the lavatory, refuse to go to bed, and be generally more antagonistic to his mother. Mrs Cohen added how her difficulties were increased by the presence in the same billet of an easy-going mother who did not keep to a balanced diet and even allowed her children to sit on the table!

Mrs Cohen also talked about her own early history, her uprooting from Germany at adolescence, and her struggles on coming to this country. She stressed her unhappiness at the sudden loss of her family's love and affection, and at her subsequent rejection by relatives in this country. She talked of her husband, so much more placid and easy-going than she was, a conscientious worker who had been with the same firm in the furniture trade for twenty-two years, and of how they had moved from two rooms in the East End to the semi-detached house they were now buying in a suburb. She also told the story of her niece, Ruth, a girl of 19, whose parents had perished in a German concentration camp and who came to live with them when Michael was 6 years old. With her help the niece had obtained a scholarship; she was successful at her job and there was a happy relationship between them. Martin, the brother aged 10, was described as a great contrast to Michael, a healthy, demonstrative, and easy-going child who was doing well at school. Michael had suffered many illnesses and separations in early childhood, and Mrs Cohen related her struggles with doctors, convalescent homes, and later with teachers and employers. Throughout this story ran a note of

alarm and guilt that she was responsible for Michael's present failure, and also an appeal for help in what to her seemed insoluble problems.

Mrs Cohen's Personality and Background

Mrs Cohen was an intelligent and sensitive person who expressed her feelings very readily and easily, burst into tears. She had been attending several hospitals for many years for a variety of ailments. She had been treated for fibrositis, for urticaria, and for circulatory trouble. The medical reports showed that the doctors considered some of these illnesses to be psychogenic in origin. Mrs Cohen was a hard and conscientious worker. Her home was spotless. Her need to get things clean by her own efforts was great, and she rejected a washing-machine that her husband had given to her to ease her burden. She maintained that the washing turned out 'grey', and sold the machine at a financial loss.

She made most of the decisions regarding holidays and household planning, as otherwise 'nothing would be done, and we would sink lower and lower'. She was a sociable and friendly person with a highly developed social conscience; she took an active part in the Jewish community life, being a member of various committees, and she visited people in hospital at great inconvenience to herself. She would always be the first person in her large family circle to come to a relative's aid and she seriously tried to live up to her religious convictions. For her, education and learning were much treasured ideals; and, ever conscious of her lack of education, she attempted to read works of literature, complaining of not being able to 'understand'. Until quite recently she had gone to evening classes in an effort to improve her knowledge of English language and literature and she fervently hoped that her children would obtain the education she lacked.

Mrs Cohen was born in Germany, the fourth of 6 children, and had a happy and uneventful childhood. Her father had a flourishing wholesale and retail tailoring business. She remembered him with pride and affection as a kind and successful man, who had her coached for entrance to an exclusive high school. He died during her childhood, and Mrs Cohen was never able to go to this school. Mrs Cohen's mother, who was still alive, gradually emerged as an efficient, active, nervy, tidy person, who

had always been exacting and dominant in her attitude. After her husband's death she ran his business with great courage and determination in very difficult circumstances. When she was staying with Mrs Cohen, she insisted on things being done immediately and in her way, and she expected special cooking. Mrs Cohen was very attached to her mother and dutiful towards her, having her to stay from time to time, and taking her to hospital for out-patient treatment several times a week. She hardly ever criticized her, although it appeared that her mother could be very irritating and demanding.

At the age of 14, Mrs Cohen, together with a sister and a brother, came over to England to the care of an aunt; she was sent to a boarding school where she felt strange and unhappy and very lonely. At her aunt's house she felt inferior, frightened, and unwanted, as the aunt seemed jealous of her, was unkind, and made her take her meals with the maid in the basement. At the age of 17 she was forced to strike out on her own and went to live in a room in the East End of London with her sister and brother on the barest minimum of food and comfort. She worked as a shop assistant and scraped and saved until they were able to take an additional room and bring the mother and another sister over from Germany.

Mr Cohen's Personality and Background

Mr Cohen was a rather heavy man, bespectacled, unprepossessing in looks, placid in manner. He took a much calmer view of Michael's difficulties and conveyed an impression of reasonableness. He had an unhurried *laissez-faire* attitude and waited to see how things turned out of their own accord. His calm acceptance of the world around him was in great contrast to his wife's eager striving and emotional restlessness. Mrs Cohen attributed his stability to his sheltered and secure youth in the bosom of a big united family in the East End of London.

Mr Cohen remembered his childhood as a happy one and he now missed the warmth and neighbourliness of the East End. He had followed his father's calling—the furniture trade—and had worked in it all his life. He had been employed by the same firm for many years as a working foreman and some time previously had been offered a manager's post, which he declined as he did not

want to take on the additional responsibility. At one stage, encouraged by the mother, he started a workshop of his own, but was unable to make a success of it and gave it up. Extremely conscientious and punctual, he never missed time from work if he could possibly avoid it. When the family evacuated to a nearby rural area during the War, the father went with them, although this meant leaving home every morning at 5.30 a.m. and returning after 8 p.m. at night.

His health was generally good, though he was very obese. He was rejected for the Forces on account of bad eyesight, poor hearing, and possibly also his obesity. Occasionally he suffered from colic and diarrhoea lasting for a day or two, which he said started soon after his marriage. During the strenuous war years he developed fibrositis.

Mr Cohen was very active in the Jewish community, an enthusiastic member of various committees, and convinced of the importance of group connections of this kind. He was described by his wife as a placid man who always avoided responsibility and left the management of home and family affairs entirely to her. He would not take time off to go to the Juvenile Court with his son when the latter was summoned for a small offence. He would not conduct correspondence about holidays, and would not take action about the most urgent maintenance jobs in the home. He was certainly not ambitious, and was satisfied with things as they were. However, he may not have been as passive as his wife believed. At a time of crisis in Michael's work career he took some constructive action, though he felt far less responsible for Michael's difficulties than did his wife. The relationship between father and son was an easier one than that between Michael and his mother, as the father was less demanding. But apart from the cinema and discussions of football, father and son had no interests in common; Michael was quite emphatic that he did not wish to follow his father's trade, nor did he enjoy group activities in the Jewish community. All in all Mr Cohen gave the impression of a well-balanced, reasonably happy person with deep roots in his Jewish community, and a fundamental belief in human goodness.

Marriage

Mr and Mrs Cohen met while they were both living in the East

End, and married when she was 22 and he 24. To Mr. Cohen, who had had such a hard struggle in her adolescence and young adulthood, Mr. Cohen, who came from a more settled and secure background, had always symbolized security and protection. Their affection for each other was great; the mother being particularly able to give expression to her warm feelings for him. In one of the interviews she contrasted their affectionate, warm bonds with the cold relationships among some of her relatives who were wealthy but unhappy. One evening she came in to find her husband preparing the hot-water bottles and Michael making the toast for supper, which made her realize how lucky she was to have such a warm and helpful family. Mrs. Cohen was aware that her husband was obese and not particularly attractive, but 'No amount of good looks can make up for the qualities in my husband'. She felt her husband appreciated her efforts: 'My husband thinks I'm wonderful and I can do anything.' She in turn was proud of her husband. At the same time she was disappointed that she did not receive more support and guidance from him and criticized him severely for his reliance on her and avoidance of responsibility. It was Mrs. Cohen whose efforts secured their present house, and it was Mrs. Cohen who saw school-teachers and employers on Michael's behalf. The episode of the washing machine, however, suggests that when her husband did try to play a protective role, Mrs. Cohen, driven by her need to make good by her own efforts, rejected his attempt.

The parents shared deep religious convictions and a great interest in their religious community. In their sexual relationship the mother was at first frightened and frigid, but through the years she had come to enjoy intercourse although she had considerable feelings of guilt about it which remained unresolved.

It seems that, in spite of their very different personalities, Mr. and Mrs. Cohen fulfilled essential needs in each other. The father gave the mother security and stability and allowed her to control things to a considerable extent. The mother's affectionate response provided the father with the satisfaction of knowing that his devotion and care were needed and appreciated. At the same time by taking upon herself the cares and worries of most of the domestic burdens, she allowed him to stay in a peaceful, comfortable rut. In addition, they shared basic beliefs and ideals which

cemented the personal bonds between them and carried them over minor disagreements.

The Cohens' Children

Mrs Cohen was very happy when Michael was born, and breast-fed him for nine months, a very satisfying experience for her. She related wistfully that she was considered a 'model mother' at the welfare clinic. When Michael went on to solids he ate very slowly or refused food altogether. He developed choking spasms at 14 months, and Mrs Cohen took him to the asthma clinic of a hospital where she felt the doctor held her up to ridicule in front of students, telling her that she was a 'stupid mother who was imagining things'. At a later stage in her contact with the Unit, Mrs Cohen remarked when surveying her relationship with Michael, 'It was my stupidity, I fussed too much,' repeating almost literally what the doctor had said. There followed other difficulties, rickets were diagnosed, and at 18 months Michael entered a convalescent home for six months where, according to Mrs Cohen, he was so much neglected that she had to remove him. On his return Mrs Cohen did not notice any anxiety or estrangement. He continued to have difficulties in walking, his legs being wobbly and thin, and the mother had to wheel him in a pram on occasions until he was 6 years old. She continued to attend hospital with him on account of his asthma, and for several years she took him for regular inspection and exercises to an orthopaedic department for his knock knees.

As a child Michael was timid, awkward, fat, and unsteady on his legs owing to his early rickets. He easily became the butt of other children who called him 'Fatty'. He was very compliant and obedient and his mother was proud of his manners and his way of keeping himself neat and clean. She related how he would salute people in a friendly, military style, and how as he grew into a bigger boy, he never came home with torn trousers or attempted any boyish mischief such as climbing trees.

Martin was born when Michael was 5, and during his mother's confinement Michael was sent to a home in the country for a month. On his return he seemed happy and friendly with the baby, but later became unfriendly, cried, and turned away from his mother for a while.

The following year the family evacuated together, and Ruth, the cousin from Germany, joined them. During this period Michael's behaviour led to increasing tensions between him and his mother. His progress at school was very slow and Mrs Cohen blamed the masters' lack of interest for this. The Head Master reports, 'He was not without general ability, but had no aptitude or liking for academic work, in spite of constant pressure from an ambitious mother. His backwardness and physical disability tended to set up reserve. Possibly he resented his mother's well-meant efforts to prod him into more energetic application to his studies.' As his full-scale I.Q. on the Wechsler test was 117, his achievement at school compared with his ability was rather poor. This lack of progress was the hardest blow imaginable to his mother, as she prized learning above all else, wanting her son to reap the benefit of higher schooling, of which she had been deprived by her father's death. She once remarked: 'If I could have helped them with their homework by stopping the clocks from ticking, I would have done so.'

In other ways too Michael resisted his mother's wishes. He showed increasing disinclination to wash and he would not get up in the mornings. The mother's anxiety reached a climax when Michael was jeopardizing his career by his persistent lateness and general inactivity, when he started to complain about his stomach, and seemed impervious to her varied attempts at helping him. Mrs Cohen felt completely overwhelmed and hopeless about the situation and described Michael as being 'at war with the world'. Michael, on the other hand became more withdrawn, silent, stubborn, unable to apply himself wholeheartedly to any kind of activity, whether at work or at home. His relations with his father remained friendly, as the father was far less upset and critical about his shortcomings. His relations with his younger brother were distant and unfriendly. He tended to ignore him.

Mrs Cohen was so deeply committed to the care of Michael that when she was expecting Martin she was afraid that she would not have enough love for this baby, as she loved Michael so much. Her relationship with Martin was an easy one, and relatively free from anxiety. He was doing well at school, showed more spontaneous emotion than Michael, and had never presented any special problems. The mother felt that Martin's better adjustment

was partly due to the fact that she was less preoccupied with him, so her relationship with him was less intense and demanding.

Family Relationships.

Although this family was in considerable distress when they made contact with the Unit and there was almost open war between mother and son, it soon became apparent that strong bonds of loyalty and affection held them together. Mutual helpfulness and spontaneous expressions of affection and appreciation were much in evidence. The family engaged in common activities, such as playing games, spending their holidays together, and entertaining friends jointly. Cousin Ruth had been completely accepted as a member of the family and her wedding was one of the highlights of family life during their contact with the Unit. The cohesive bonds extended further, beyond the family into the Jewish community. Although the family had only recently come to the neighbourhood, the parents were already firmly established in their local Jewish community and their house had become a centre for many of its activities.

As in the Brown family, domestic life seemed to hinge on the strong personality and the needs of the mother. Her ambition, her idealism, and her contradictory needs to control and yet be supported, were the main driving forces in the family. Less concerned with status and material advantages than Mrs Brown, she attached the very greatest importance to education and learning as values in themselves, a phenomenon often found in Jewish culture. It is also possible that these non-material values become more important to people who, like Mrs Cohen, have been uprooted. Mr Cohen did not feel nearly as deeply about these matters.

In this context Mrs Cohen's extreme and almost intolerable anxiety becomes readily understandable as her son attacked the very values she had tried to foster. He was dirty, unpunctual, unhelpful, lazy at school and at his work, when to her, cleanliness, punctuality, learning, and devotion to duty were supremely important. She gradually came to see that her saying 'he is at war with the world' meant that he was at war with her.

Mr Cohen, secure in his family tradition, did not have such high expectations, and was correspondingly less disappointed. Whereas the mother looked upon Michael's failure as a catastrophe, Mr

Cohen looked into the future with quiet optimism—his boy would gradually find his niche. However, his optimism was not active enough to help Michael in his struggle with his mother, and for a time it was the psychiatrist at the Unit who took on the role of the strong helpful father this boy needed. The marital relationship, though deeply satisfying in many respects, was also bedevilled by Mrs Cohen's contradictory needs. After being uprooted in adolescence and experiencing severe hardship and emotional deprivation, she needed her husband as an anchor of security, and as someone who would love her unconditionally. She did find a man who accepted and loved her wholeheartedly, who thought that 'she was wonderful and could do anything', and this was a deeply gratifying experience for her. But she wanted more than security; part of her was also longing to be protected by an active and effective husband on whom she could lean and whom she could admire for his resource, initiative, and position in the world. She had a fantasy of being passive, wanting to 'sit in a rocking chair and let things be'. Her husband was unable to fulfil this need, partly because of his own passive, easy-going personality and partly because there was also an opposing need in the mother to control and to dominate her environment. This need, like her need for security, may have been stimulated by her experiences in late adolescence when she had had to struggle against great odds and only won through by persistence and ability.

One of Mrs Cohen's solutions to her dilemma of seeking incompatible virtues in her husband lay in trying to shape her son into what her husband might have been, and so to make up for his deficiencies. Less pressure was put on Martín, who grew up in a more care-free and spontaneous manner, like a plant which is allowed to grow without too much pruning.

CHAPTER III

Family Life and Duodenal Ulcer

SOME HYPOTHESES

COMMON CHARACTERISTICS OF THE THREE FAMILIES

The three families were chosen to illustrate different types of family relationships, and more particularly different kinds of maternal behaviour. At the same time, a comparison of the three families shows some important similarities in the ethos of the families and the personalities of the mothers and fathers, in the type of relationship they had with their sons, and in the sons themselves.

The Families

The three families had put much effort into building up their homes, which had an air of respectability and solidity, and of which they were proud. Hard steady work and conscientiousness were highly prized. But the Browns and Cohens carried these ideals much further into the spheres of education and status than the Allens, who attached equal importance to personal happiness and enjoyment of life.

Family bonds were tight despite tensions, which were particularly pronounced in the Brown and Cohen families. None of the sons was contemplating leaving home because of these difficulties. On the contrary, all preferred to work as near home as possible.

The balance of forces that kept the families going was very similar. The mothers were the initiators and leaders. They had in common a quality of restless striving, whether pursuing adolescent pleasures, educational ideals, or dreams of higher social

status. The fathers seemed satisfied with their lot and contributed a steady element.

The parents had taken their parental duties very seriously in bringing up their children. In the Brown and Cohen families the mothers, and in the Allen family the father, were anxious worriers.

The patients in each case were the eldest surviving children and separated by more than five years from their siblings. They had responded compliantly on the whole to their parents' conscientious example. They were 'good children', especially during their early childhood. At adolescence they showed signs of rebellion, but none of them carried this very far. The younger siblings had less intense and more easy-going relationships, particularly with their mothers and they showed greater spontaneity in expressing their feelings, and in their activities generally.

The Mothers

Despite their different personalities, the three mothers have a good deal in common, both as regards their family background and their means of solving problems. This is perhaps all the more remarkable because they came from very different social settings. Mrs Allen, Mrs Brown, and Mrs Cohen all had mothers who became seriously dependent on them. Two of the grandmothers were invalids, and the third had to be supported economically and socially when she came to this country. At the same time the Brown and Cohen grandmothers were felt as powerful and exacting women, while the Allen grandmother's illness seriously restricted Mrs Allen's own life. The mothers showed outward signs of dutiful obedience to the maternal grandmothers and apparently they did not allow themselves to express any resentment. They all saw their fathers as successful and effective men who, unlike their husbands, had founded or managed businesses. (Whether this picture corresponds with reality, we have no means of knowing.) These women married men who were in many ways the opposites of the maternal grandfather. In their eyes at least their husbands' occupational achievements were less than their fathers'; they easily slid into a rut and were satisfied with comparatively subordinate positions. All three women expressed a certain amount of disappointment in their husbands: Mrs Allen by

implication, in comparing the zest and success of her father with the quiet plodding of her husband; Mrs Brown and Mrs Cohen by voicing open criticism.

The aspirations of these mothers had been frustrated. Mrs Allen's father had not allowed her to go out to work and so prevented her from sharing the activities of other young people at work and during leisure; Mrs Brown had sisters who, she felt, were much more attractive than herself and who succeeded with young men where she did not. Mrs Cohen's educational ambitions had been completely thwarted. They were exceptionally hard workers, who did not spare themselves, who had a pronounced conscience, and placed great emphasis on duty. They all showed considerable preoccupation with tidiness and cleanliness and could be called 'obsessional characters'. Their ties with their sons were close. They found it exceptionally difficult to let them grow away from them towards independence and they felt themselves in some way responsible for their illness.

These common patterns of behaviour are susceptible of a number of interpretations, and it is possible to speculate about the underlying motives in various ways. The choice of husbands who were in important respects unlike their fathers may indicate a strong defence against their deep attachment to their fathers. It looks as if their love for their fathers had taken on new life in the shape of their ideals for their sons. The choice of a somewhat unassertive husband may also represent a wish to assume part of the masculine role themselves. Mrs Allen's sense of protectiveness in relation to her unemployed fiancé and Mrs Cohen's rejection of her husband's protecting rôle are both relevant points of evidence here. This choice finally may be an attempt to identify with their powerful mothers in controlling people.

One also wonders why these women had to be so hard on themselves and placed so much emphasis on duty. It seems that all these three mothers had uneasy feelings of guilt about their 'badness', which they had to counteract by setting themselves exacting standards of behaviour. Mrs Allen may have felt uneasy about leaving her crippled mother behind. She almost certainly felt guilty about the death of her babies and about her initial rejection of Derek. She was aware that her indulgence towards him and her almost compulsive need to give him presents were means of making

up to him, for the things she failed to give him in early childhood. There are many indications in Mrs Brown's story that she felt herself to be an unworthy and unlovable person, less beautiful and 'good' than her sisters; at one and the same time impelled to assume a 'Cinderella' role and resenting it. Her conscience was a severe, punishing one, both for herself and for her children. Mrs Cohen too had doubts about her own worthiness. Her feelings of responsibility for her son went so far that she traced his illness back to her bad milk, which she thought was connected in turn with the hardships and undernourishment she had suffered in her youth. This fantasy of having passed on bad things to her baby provides a clue to her protectiveness at two levels: at the level of reality she wanted to protect her child from the sufferings and hardships she had endured in her youth. At a deeper, less rational, level she was a 'bad' mother who had given her baby 'bad' milk, and was then compelled to make reparation for it ever after.

Such conflicts about their own badness may account for the ambivalent and conflicting attitudes of these mothers towards their sons. In those aspects in which the sons represented the bad, aggressive part of themselves (particularly their repressed rebellion against their own mothers), they appeared to reject them. They tended to accept them in those respects in which they represented their ambitions or their ego-ideals. They dealt with their partial rejection in terms of their particular type of conscience. Mrs Allen made reparation by over-indulgence. Mrs Cohen was continually guarding against her rejecting feelings by anxious over-protection. Mrs Brown showed her feelings of rejection openly by voicing strong criticism and by punishing and restricting. The ideals that they urged their sons to attain reflected the ambitions they had had for themselves. Mrs Allen wanted her son 'to have loads of fun' and a clean, sociable job. Mrs Brown wanted her son to be ambitious and to get on in the world, i.e. by becoming a solicitor. Mrs Cohen wanted her son to receive the education she did not have. Their gratification when their sons achieved the ideals so dear to them was quite striking. Mrs Allen's description of her son's wedding and their enjoyment of it was so vivid that she might have been describing her own wedding. Mrs Brown's delight on hearing the results of her son's intelligence tests and on

realizing that he had great potentialities was intense. Long after she had ceased attending the Unit, Mrs Cohen telephoned every time Michael passed an examination, to share her pleasure with the P.S.W. She felt that at last her educational ideals had been adopted by her son.

Another question that arises is why these mothers felt so strongly about their frustrated aspirations. It is possible that approaching middle-age and the completion of their maternal tasks helped them to become once more aware of their earlier frustrations. However, there is some evidence to suggest that their frustrations had deeper causes, particularly in the case of Mrs Allen and Mrs Brown, which point to a difficulty in self-assertion, a feeling almost as though they did not deserve the good things other people have. However that may be, the three mothers attempted to solve their problems by using their children to satisfy their own frustrated ambitions. Their contradictory strivings created considerable difficulties, both for them and for their sons. On the one hand they were pushing their sons to succeed in ways which were not open to them and which lead to independence. On the other hand they wished to hold on to their sons and tie them to their apron-strings. Mrs Allen sat up for Derek with his cocoa. Mrs Brown arranged with the Post Office to ring Peter in the morning when she was on holiday, and was for ever probing to find out all that went on in her son's life. Mrs Cohen had a similar habit of probing and wanting to know about Michael's activities and feelings down to the smallest detail.

Finally, the tie between mother and son had an erotic element in it. Two mothers expressed openly their guilt about their sexual relations with their husbands *vis-à-vis* their sons. Mrs Allen felt it was nice to sit up for her son at night and keep him company for supper so that he should not feel too badly about her withdrawal into the bedroom with the father. Mrs Cohen said she would not be able to face her son if she told him about sexual intercourse because of its reference to herself and her husband.

It goes without saying that the mothers were largely unaware of such possible driving forces and aims in their attitudes to their sons which were for the most part unconscious, although they achieved limited awareness of some of these attitudes during their contact with the Unit.

The Fathers

The fathers too share certain characteristics and ways of dealing with their lives. The three fathers were very steady and conscientious in their work. They rose in position, but they were relatively unadventurous and none of them had striven towards or attained executive responsibility. All three fathers were quiet, peaceful men who liked their own firesides, and who fitted in with their wives' demands. Two fathers took an active interest in their sons when they were small, but tended to lose touch with them during adolescence, and shared very few of their interests and activities. They appeared to be stable, solid personalities, with a suggestion of depressive colouring, particularly in the cases of Mr Allen and Mr Brown.

There is not enough direct information about the fathers to indicate how these attitudes might have arisen, but it is plain that these men were in a difficult position *vis-à-vis* their wives. Their wives expected them to succeed as the maternal grandfathers had done and as their own unexpressed masculine aims demanded. If they were not successful their wives would be disappointed; if they were very successful they would envy them. Perhaps these fathers had decided that the safest way was to steer a middle course between failure and great success, which best fitted in with their wives' complex needs.

The stability of the marriage itself seemed to be achieved along similar lines, the somewhat passive husband accepting the more active dominant wife. In the Allen and Cohen families, this distribution of roles seemed deeply satisfying to both partners and productive of much affection and harmony. In the Brown's marriage such a harmonious solution was not achieved, possibly because Mrs Brown rejected to a greater extent than Mrs Allen and Mrs Cohen her feminine role, which had been severely tested by her nursing duties. The hopeful beginning of the Brown's marriage may point to the possibility that they too could have worked out a similar arrangement if they had remained undisturbed by the incursion of her relatives. However, Mrs Brown's ambitious drives on the one hand and her feelings of unlovableness on the other might have made it impossible for any man to fulfil her diverse needs.

The Sons

There were also certain striking similarities between the three boys. They showed little overt aggression in childhood, particularly outside their homes. Torn trousers, fights, mischievous adventures, were conspicuous by their absence. Their relationships with their mothers were intense and the latter seemed ever present, even in adulthood. Peter and Michael both had ambivalent feelings towards their hard-driving, ambitious mothers. Outwardly compliant, they put up a great deal of 'passive resistance' (lack of achievement at school, for example), against their mothers' demands. This resistance became a more active struggle as adolescence approached. These two boys also shared a pronounced inhibition of feelings. This was not so marked in Derek who displayed much less hostility towards his mother. She, for her part, made far fewer demands on him and was less controlling and managing, and he seemed satisfied to remain dependent on a mother who gratified most of his wishes. The relations of the sons to their fathers were less definite and more varied, ranging from the rather distant to the friendly. These relations in general seemed less highly charged with feelings. There was no evidence that they entailed the kind of struggle that occurred between the boys and their mothers. Their relations with other boys of their own age seemed restricted in scope. Two were solitary children, and one was a 'hanger-on'. Their achievements at school were not outstanding, and probably less than they were capable of. There were no obvious signs of those ambitious strivings which are said to characterize middle-aged men with ulcers. All three displayed psychosomatic reactions in childhood. In two these occurred in a 'crisis situation' (Lindemann, 1950) when the security of their accustomed social setting had been disturbed. Derek developed his asthma when his father went into the Army, and Peter his temperatures during his stressful time at the big school. It is possible that Michael's early asthmatic symptoms were connected with the withdrawal of the breast and the frustrations of trying to walk.

How can we interpret these modes of behaviour? It seems that these three boys responded positively to their mothers' careful training, and in particular accepted their bar on the direct expression of aggression. In their attempts to rebel against their

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mothers' ambitious pressure, Michael and Peter received little support from their fathers, who had accommodated themselves to these maternal strivings. Eventually the young men identified themselves to a considerable extent with their mothers' ideals. They became more ambitious and applied themselves to their work and so gradually fulfilled their mother's expectations. On the other hand, Derek, whose mother did not make such ambitious demands on him but found satisfaction in gratifying his striving towards happiness, remained openly dependent, although he was the only one of the three who married early. It is possible that the histories of Michael and Peter illustrate the genesis of the *independent* type of ulcer patient (Alexander, 1948), who incorporates his restrictive ambitious mother and denies his dependent wishes, while Derek represents the *dependent* ulcer patient who basically remains his mother's baby and whose aim in life is immediate gratification.

These three case studies and the tentative interpretations of them reveal something of the psychopathological elements at work within the families. It may well be that these families are not exceptional in our society today. The case studies may reflect problems of family adjustment resulting from the changing roles of women. Women are now able to perform roles that were formerly considered to be 'masculine'. Not every woman has the opportunity to assume these roles, but many of them feel that it is no longer enough to be 'just a housewife'. At the same time, there are fewer opportunities for creative home-making 'feminine' activities. Families are smaller, more labour-saving devices are available, pre-cooked foods and ready-made clothes are much cheaper. It is surely no accident that these intelligent, potentially creative women spent so much of their time polishing their small homes and trying to live their creative lives through their children. All three women very much wanted to have activities outside their families and to go out to work, but only one of them actually achieved this. These case studies also hint at the increasingly high standards of child care in our society and at the growing concern of parents with the personality development of their children. These trends add new purposes but also new anxieties to the task of parenthood. Further, the histories illustrate another general problem of family life today, namely the close involvement of

parents and children with each other, almost inevitable in small families where children are much more exposed to the emotional conflicts of their parents. Finally they point to the growing uncertainty of the father's part in the bringing up of children, a necessary corollary of the mother's increasing overt leadership in the home.

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CHAPTER IV

The Mothers' Natal Families and Personalities

The approach to the case material will now be different, as the two samples will be compared for various specific characteristics. Complete individual histories will no longer be presented but the material will be scrutinized for the presence or absence of certain features (or of constellations of these) that emerged from the pilot study and that were also observed in the three case studies just presented. Wherever possible, the findings are set out in the form of simple tables extracted from the case histories, and typical examples will illustrate these findings. This inevitably involves, for purposes of description and measurement, the artificial isolation of items of behaviour that in reality are interwoven with others. But only by defining certain characteristics and examining their interrelations can such comparisons be made. If sixty-four complete case histories were presented such comparisons would of course not be possible. However, by comparing first some characteristics of the mothers and fathers in both samples, followed by a discussion of various phenomena of their marital relationships and of the young men's childhood, it is hoped to build up gradually a picture of the 'DU family'. Although tables are presented for clarity and for the indication of trends, tests of significance have not been carried out. The numbers are small and the variables are highly interrelated and such tests might in fact give an impression of spurious precision.

It is commonly accepted that the mother exerts the most fundamental influence on the early development of her child's personality. Further, the three case studies showed how the mothers' personalities and needs dominated the lives of the families. The major emphasis is therefore laid upon exploring the attitudes of the mothers, who were also more readily accessible.

Our pilot study (as well as the three case studies) seemed to indicate certain common patterns in the mothers' childhood experiences and relations with their parents, and typical personality traits and attitudes towards their own children. These can be summarized for the mothers in the DU sample as follows:

1. *The mothers' backgrounds:* The mothers often show a close unresolved tie to one or other parent who is usually seen as a successful person.
2. *The personalities of the mothers:*
 - (a) *Mental health:* The mothers frequently show emotional disturbance in the form of anxiety and obsessional symptoms. There is a marked tendency to psychosomatic symptoms.
 - (b) *Dominance:* The mothers are usually dominant, controlling, and striving people who make the major decisions in their families, are the leaders in the home, and the source of authority. They often marry passive, unassertive men, who can adapt themselves to their wives' needs.
3. *Attitudes to child care:* The mothers usually take very special care and exhibit much anxiety and conscientiousness in the upbringing of their children. This anxious care appears in three main ways:
 - (a) in *restrictive attitudes* shown in careful control of the child's activities,
 - (b) in *over-indulgent attitudes* revealed in excessive gratification of the child's needs, and
 - (c) in *protective attitudes* displayed in anxiously guarding the child against dangers, real and potential.

In general the mothers are far from easy-going. Their concern with child care is reflected in the fact that during the first ten years of the child's life they go out to work less than the control mothers.

Specific child-care practices, for example in the spheres of feeding and toilet training, were explored but the information obtained did not suggest any differences between the two samples.

THE NATAL FAMILIES OF THE MOTHERS

All three mothers in the detailed case studies already presented experienced severe frustration and unhappiness during later childhood and adolescence. Current notions emphasizing the relationship between an unstable family background and childhood problems might lead to the supposition that these mothers, and perhaps the majority of the mothers in the DU sample, came from disrupted and badly disturbed families. This was not so. Mrs Allen, Mrs Brown, and Mrs Cohen came from closely knit families, and the mothers' problems in relation to their sons appeared to reflect close unresolved ties to parental figures, rather than broken relationships. In terms of gross unstable features in the mothers' backgrounds, such as broken homes (through death, separation, or divorce) or severe rejection by either parent, there was hardly any difference between the two samples, as the following table shows:

Table 5
UNSTABLE FEATURES IN MOTHERS' BACKGROUNDS

	DU	Control
Death of either parent during mother's childhood	5	4
Severe rejection of mother by either parent	2	3
Divorce or separation of mother's parents	2	2
No such evidence	23	23
Total	32	32

When the material was analysed to discover the extent to which the mothers had a strong emotional tie to either of their parents as exemplified in the three detailed cases, the figures showed a different trend:

Table 6
THE MOTHERS' RELATIONSHIPS TO THEIR PARENTS

	DU	Control
Strong emotional tie	12	6
No evidence of strong emotional tie	11	15
Not rated (insufficient evidence)	9	11
Total	32	32

Twelve mothers in the DU group showed evidence of such close ties, either positive or negative, in their histories as against 6 mothers in the control sample. The numbers in the category 'No evidence of strong emotional tie' and 'Not rated' are large for two reasons:

1. It is difficult to obtain evidence for this hypothesis in relatively short-term work with middle-aged people, especially when the main emphasis was upon their relations with their own children, and where consequently their attitudes to their parents could be explored to only a limited extent. Often these attitudes were heavily overlaid by subsequent experiences and so not immediately accessible.
2. Mothers were rated as having a strong emotional tie to either parent only if they showed clearly and unmistakably such a close involvement with, or child-like dependence upon, a parent that this overshadowed their interpersonal relationships, even in middle life.

Among those rated as 'No evidence of strong emotional ties to a parent' were women who had close, warm, and positive relationships with their mothers and fathers, visiting them frequently, helping them in crises, but who at the time of the investigation had become emotionally independent of their parents. For example:

A DU mother, Mrs Abbott (DU 1)¹, in her youth and early married life was very much identified with an excessively houseproud and prudish mother. 'Her house looked as though it was made of glass.' She had gradually emancipated herself from her tie with her mother, had become more easy-going and able to enjoy her sexual relationship with her husband and was aware of this development in herself.

A control mother, Mrs Baker (C 1), had always had a warm and happy relationship with her parents, admiring her mother, taking her advice, and visiting her regularly. When she died she was deeply affected. She reviewed her mother's happy and useful life and described vividly her serene acceptance of her approaching death surrounded by all her children. Although

¹ The letters DU and C refer to the ulcer and control samples respectively.

Mrs Baker indicated that her mother had been the most important person in her life, she seemed able to let her go, as it were, feeling that she had successfully completed her life's task. There was no excessive mourning or self-accusatory regrets for things undone.

Among those rated as having a 'Strong emotional tie' to a parent were the following:

Mrs Austin (DU 2) discussed her relationship to her parents in almost every interview. She felt herself to be rejected by her mother, who preferred boys, and felt that she had never been forgiven for not dying instead of her brother. There were long descriptions of the gentleness and loving care her father had bestowed on her and many stories about his success and generosity.

A similar example from the control group was Mrs Hodges (C 2) who felt that her mother had rejected her and favoured a brother. She had to work hard in a Cinderella-like fashion while her mother and brother went out. She continued to be over-active and excessively hard-working in later life as though she was still needing to gain the approval of her mother.

A further example was Mrs Gilbert (DU 3) who was the ugly duckling in her family, the odd one out with much physical inferiority, who clung to her mother throughout her life, relying on her for the upbringing of her children. She attempted to use the P.S.W. as a mother substitute after her mother's death, saying that she now had nobody to confide in.

Thus, 12 mothers in the DU sample and 6 in the control sample seemed to be so closely tied to one or other, or to both parents, that they were in danger of re-living their childhood conflicts in their marriages and in their attitudes towards their children.

The pattern most commonly found was one in which the mother attempted to identify with her own strong effective mother, to whom she often felt inferior, and had a profound admiration for a gentle, loving father, who was successful in his work and in whose image these mothers often attempted to recast their sons. Both parents were frequently idealized in the DU sample and only very rarely did the mothers express any

hostility towards or criticism of their parents, least of all of their mothers. On the other hand five mothers in the control sample who had dominating, strict or rejecting mothers, talked freely about this, and vented their negative feelings. Similarly more mothers in the control sample expressed hostility towards and criticism of their fathers who drank or were otherwise neglectful, although there were just as many indications of heavy drinking and other forms of antisocial behaviour existing among the grandfathers in the DU sample.

MENTAL HEALTH

The hints that the mothers in the DU sample had a closer tie to their parents and were less able to express criticism of them than the mothers in the control sample, suggest that there might be a greater degree of neurosis and psychosomatic disturbance, which are so often associated with unconscious conflicts about aggressive impulses. Two mothers in the detailed case studies showed evidence of neurotic and psychosomatic symptoms and all three were obsessional personalities. These pointers find some confirmation in the case material for the whole sample.

Obsessional Tendencies

Mrs Allen, Mrs Brown, and Mrs Cohen had a highly developed sense of duty and love of cleanliness, and they were extremely conscientious. Altogether 18 mothers in the DU sample as against 8 in the control sample showed similar tendencies. Their conscientiousness, efficiency, and meticulous cleanliness in the house were a constant source of surprise to the P.S.W. For example, two of the DU families lived in a tenement notorious locally for its roughness and squalor. Entering these two flats it was difficult to believe that they were part of this building. They gleamed with polish, the walls were brightly painted, they were carefully furnished, additional amenities such as shelves and cupboards had been made and fitted by the fathers, and an air of middle-class respectability pervaded them. Several mothers were aware of their exaggerated love of cleanliness and related half jokingly, half apologetically, their particular way of responding to this urge. They washed their paintwork several times a year. One of them

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pointed out that her curtains were the cleanest in the neighbourhood. One husband declared that he would put a dustpan and brush in his wife's coffin with her; another mother waged a never ceasing war against moths all the year round. One mother used to give her children three clean handkerchiefs a day; another related several times how she used to scrub her washing tubs until they were white, and another gave a detailed account of her elaborate methods of washing up. Other mothers discussed such matters as how their consciences troubled them, their preoccupation with carrying out their duties adequately, and their concern with what other people might think of them. Some felt that their need to be so fussy was diminishing in middle age and that they were able to take things more easily; it seemed to have been at its height in their early married days when the children were small. Only one mother in each sample showed clear signs of becoming more obsessional in middle age when she had more time on her hands.

In the control sample strong "obsessional" tendencies were far less common (8) and where they did occur they seemed to be more like an illness than like traits which form a part of generally efficient personalities. For example, there were four restless, compulsive workers who drove themselves day and night, went out to work, did an excessive amount of housework, were forever waiting on their families, decorating, dressmaking. These four women had considerable insight into their need to drive themselves relentlessly but were unable to do anything about it. Whether the different 'feel' of obsessionalism in the two samples is due merely to chance or has deeper implications, I cannot say.

Table 7 MENTAL ILL-HEALTH AND PSYCHOSOMATIC
DISORDERS IN THE MOTHERS

	DU	Control
Psychosis	1	0
Neurosis (severe to mild traits)	10	11
Psychosomatic symptoms	12	1
No overt symptoms	8	17
Not rated (Information insufficient)	1	3
	32	32

Psychosomatic Disorders

The other striking feature among the mothers in the D U sample is the high proportion (38 per cent) who had physical disorders that contained psychological components which may be termed psychosomatic. Only one mother in the Control sample showed this kind of disorder.¹

Mrs Blake (C 3) who had recurrent attacks of dyspepsia, had been examined at the hospital to see if she had an ulcer. The findings were negative. In addition she had numerous neurotic difficulties. She was frigid, had phobias, and was obsessional. She had a close tie to her mother whom she saw every day, and was unable to respond in a constructive way to the demands of a difficult husband, although she was able to give devoted care to a lonely old man in the district.

The twelve mothers in the D U group had the following complaints:

1. *Migrainous types of headache.* Four mothers suffered from severe recurrent attacks of migrainous types of headache that put them out of action for a least two days at a time. In addition one of these had a duodenal and one a gastric ulcer. All four were very active, conscientious, and intelligent women, who ran their homes very efficiently. Only one, Mrs Austin (D U 2), showed overt signs of emotional disturbance in addition to her migraine.

As a girl she used to have frequent fainting fits, which still occurred occasionally. These attacks happened dramatically when the girls at the factory started talking about sex. She had a breakdown when her D U son was 3 years old; the symptoms were trembling of hands and legs, general debility and depression. This coincided with the beginning of a very early menopause. She was excessively houseproud and fastidious and had always tried to restrain her son's 'messy' artistic activities; she used to throw away his paints and pencils, and later disapproved of his bold style as an artist and of his paintings of nudes. Mrs

¹ There were also two cases of rheumatoid arthritis which may or may not be considered to be 'psychosomatic'.

Austin has already been mentioned as a woman closely tied to her parents, and her family background showed some of the features described in the three detailed case studies; she had a hard and efficient mother who was likened to 'a nurse who does the needful efficiently and without sympathy', and by whom Mrs Austin felt greatly rejected, and a gentle, loving, and generous father, the owner of several shops, whom she adored.

All these four women suffering from migraine were able to utilize their energies very effectively, and on superficial acquaintance they gave the impression of being well-adjusted people. It was only after prolonged contact that their over-conscientiousness and driving activity became apparent.

2. *Disorders of the gastro-intestinal tract.* Two mothers were found to have a duodenal ulcer. In both instances they were diagnosed while they were in touch with the Unit, and after the sons' illnesses had become apparent. Another mother suffered from recurrent dyspepsia, which was relieved by alkaline tablets. One had recurrent attacks of colitis. A fifth had diffuse symptoms of nausea, abdominal pains, palpitations, backaches, headaches, etc., which were diagnosed by the hospital as being 'functional' in origin.

Mrs Franklin (D.U.4) had suffered from indigestion for many years, and an ulcer was eventually diagnosed. She was a very obsessional woman who was reported to have a compulsive need to clean even when other members of the family had already done the work. She was greatly overprotective of her children, and could hardly bring herself to let them go. Her daughter had slept in her room until her marriage. The grown-up son still slept in her room. She dominated her husband, who was placid and tolerant.

Mrs Henderson (D.U.5) had suffered from severe bouts of migraine for many years. In one of her attacks she vomited some blood, and on admission to hospital was found to have an ulcer. She was a gentle, rather tense woman with a highly developed conscience and a need to be continually 'on the go'.

Mrs Cameron (DU6) suffered from chronic dyspepsia—a gnawing pain relieved by Maclean's powder. She too had recurrent headaches. She was a very effective and accomplished woman, who grew up on a smallholding in the Highlands of Scotland and married the son of a neighbouring farmer. She was determined to break away from this primitive environment of hard physical work. As a young girl she had worked as a domestic servant in London, and when her son was 9 months old, she persuaded her husband to try their luck in London, leaving the baby in the care of the maternal grandmother. She stressed that she would have gone without her husband if he had refused. Although her quiet, dependent husband never had more than a modest job, with a much lower income than that of the average skilled worker, this mother managed to work and save until they were able to buy a pleasant house in the suburbs.

Mrs Cross (DU7) had recurrent attacks of colitis. Her whole life history was one of complete dependence on her mother and of inability to shoulder the responsibilities of marriage and motherhood. She was an immature, frigid woman, who had left her husband and returned to her mother when her only child was 5 months old. She was unable to break away from her extremely dominant and unstable mother, and left the child in her care while she went out to resident domestic work. She never built up a home of her own again; later she shared a bedroom in the house of a relative and had no possessions except a dog which, having no other friends or social contacts, she personalized to an exaggerated degree.

Mrs Clayton (DU8) was a grossly obese woman who complained of nausea, abdominal pains, palpitations, backaches, headaches and frequency and urgency of micturition. The hospital doctor considered her symptoms to be due mainly to anxiety. She had been confronted by a series of very difficult problems. Her first husband, who had been unfaithful to her, died, although her son reported that she herself had gone off with another man. She was acutely unhappy in her second marriage to a near-defective man whom she despised. Many of her symptoms seemed to develop after her son and daughter

left home because they could not get on with the stepfather. She was deeply hurt by her son, who was attempting to climb socially and felt ashamed of her.

3. *Skin disorders.* Three mothers had skin disorders that they themselves and their doctors recognized to be to a considerable extent psychologically determined.

Mrs Davies (DUG) had a rash on one side of her face that recurred whenever she was worried and that her doctor considered to be 'nerves'. In addition she had some form of alopecia, which the doctor also put down to 'nerves'. She was the daughter of a conscientious and successful man of whom she was proud and who helped her a great deal during her difficult married life. She married a man who drank to excess and who did not help her in building up a pleasant home. This woman, who took a long time to reveal any of these marital difficulties, was outwardly cheerful and easy-going and minimized the serious tensions in family relationships that were always present.

Mrs Bird (DU10) developed eczema on her hands when she underwent severe stress during her husband's final illness. This was her second husband whom she had married for security, and whom she had never loved. She felt sexually repelled by him, and resented his prolonged illness and demandingness, stressing in several interviews that he had done no work for five years. The eczema recurred whenever she was worried. She feared that this complaint had been passed on to her by her sick husband in the form of 'poisoned blood' and she felt concerned lest she in turn might pass it on to others. She was a highly obsessional woman who gave long descriptions of her compulsive need to clean. She had modelled herself on her mother, who was greatly admired, and described as an extremely capable, stately, and, if anything, even more obsessional woman with clearly defined concepts of duty.

The third mother who showed persistent skin complaints was Mrs Cohen. Her doctors felt that her condition was due to her emotional conflicts. The distribution of her rash was consistent with her guilt over sex, which she discussed a great deal.

4. *Exophthalmic goitre*. One mother had an operation for exophthalmic goitre.

Mrs Hill (DU 12), was a woman with a good deal of anxiety who cried easily and readily converted anxiety into physical pain. She had had an unhappy and unsettled childhood, having lost her mother when she was 5 years old. Her eldest son was deaf and dumb. Her goitre developed suddenly a few months after her DU son married. The time of her operation coincided with his first attendance at the hospital on account of his duodenal ulcer. She was not consciously opposed to the son's marriage, which was the culmination of a boy-and-girl friendship. However, Mrs Hill had always wanted this son to be a girl, and had done her best to bring him up to be one. She had a conviction that the girl he had married would never be able to produce any children.

The concentration of psychosomatic disorders in the mothers of the DU patients was unexpected, and its full explanation is beyond the scope of this inquiry. There are, however, some leads that may be worth pursuing. The women who suffered from psychosomatic disorders had certain features in common, particularly reminiscent of Mrs Brown and Mrs Cohen, who also had psychosomatic complaints: their great conscientiousness and persistence, their submission to their effective and powerful mothers on the one hand, and their domination of their husbands on the other. Nine of the twelve women suffering from psychosomatic disorders had mothers who were either dominant or very effective or both. They felt that their mothers were superior in their achievements as mothers and homemakers, but they hardly ever expressed negative feelings towards them. They had nearly all been dutiful daughters who accepted their mothers' advice. Ten of the twelve mothers with psychosomatic disorders were rated as 'dominant', that is to say they were the leaders in their families and made the decisions on most matters. This is a much higher proportion than obtains for the group as a whole (see p. 72). With the exception of three women who had become discouraged by an unsuccessful marriage (Nos. 7, 8, 9), they were of the very conscientious type who worked hard, did not give up in the face of great difficulties; and seemed unable to relax.

For example:

Mrs Henderson (D U 5) insisted on working long hours although she had had a severe haematemesis not long before and did not have to do so. Her husband acted as a kind of chauffeur, driving into the centre of the town every night after his work in order to meet her.

Mrs Abbott (D U 1) was working full time and found in this a means of escape from a difficult daughter-in-law situation in her home. She did her housework in the evenings and read at least one library book a day till 1 or 2 a.m.

This need to work hard and to be severe with themselves is very like the devotion to duty and the exacting standards of behaviour demanded of themselves by Mrs Allen, Mrs Brown, and Mrs Cohen, which seemed to provide them with some reassurance of their worth. It is also possible that these activities contained an element of striving after dominance and independence. These women wanted to accomplish things by their own efforts and did not wish to be helped by anybody else. It is possible that the symptoms—particularly in the cases of complete collapse in the severe migrainous attacks—gave them a legitimate reason for letting up and for being looked after, enabling them to express their need for protection and dependence which they hardly ever allowed to come to the surface at other times.

5. *Neurotic traits.* There were remarkably few differences between the two samples in respect of neurotic traits or serious neurosis. One mother in the D U sample was psychotic. She had been certified twice and still had many paranoid delusions. Ten others showed some degree of neurotic disturbance ranging from fairly severe conditions to mild symptoms. (Several of the mothers with psychosomatic disorders also had neurotic symptoms.) There were eleven mothers in the control sample who had manifest neurotic traits. From the few pointers available from other studies (Fraser, 1947, pp. 4, 18, 27; Gorèr, 1955, p. 282) this degree of emotional disturbance in women is not unusual in an urban sample of our society. There were no obvious differences in the kind of disturbances found in the two samples. They both included anxiety states of various types, paranoid symptoms,

hysterical symptoms, and others. Instances from both samples will be found in Appendix II.

While it was considered important and interesting to indicate the frequency and the kind of neurotic disturbance found in the two samples, it needs to be stressed that most of these women were able to lead effective and in many respects satisfying lives. Only a minority of cases in either sample showed neurotic disturbances that were so crippling that active treatment might have been advisable. The chapters on marriage and family relationships show some of the ways in which human needs are fulfilled or frustrated in interpersonal relationships and suggest that there are more meaningful indications of the efficiency of individual and family functioning than the mere presence or absence of overt neurotic signs or symptoms.

Mothers without Neurotic and/or Psychosomatic Symptoms

There were eight mothers in the DU sample who had no neurotic or psychosomatic symptoms. Whether they functioned more effectively than some of the mothers with overt symptoms, however, is questionable. Five had obsessional tendencies, and two of the most dominant and difficult women were found among these eight. In the control sample only one of the seventeen symptom-free mothers showed strong obsessional tendencies. Again, lack of symptoms did not necessarily mean that all these women were particularly well adjusted. However, it is certainly true that among the seventeen a great variety of personality-types were encountered, well able to meet life's challenges, ranging from conscientious, hard-working, dominant women to easy-going, warm, light-hearted mothers, who knew how to enjoy life and who took things as they came.

To summarize: features that differentiated the DU mothers from the mothers in the control sample were: the strong obsessional tendencies in the DU mothers expressed in their excessive house-proudness; a high degree of conscientiousness and a need to drive themselves hard; and their proneness to psychosomatic ailments.

DOMINANCE IN THE HOME

The discussion of the mental health of the DU mothers, and more especially the three detailed case studies, have thrown into relief

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their dominance over their husbands and families, their ambition, and their need to live up to exacting standards. There were remarkable differences between the two samples in these respects.

Table 8 MOTHERS' DOMINANCE IN THE HOME

	DU	Control
Very dominant	15	8
Dominant	7	2
Equal sharing with father	5	14
Submissive	4	6
Not rated (insufficient information)	1	2
Total	32	32

The following criteria were used in assigning the mothers to various categories:

- (i) *Very dominant*—those women who can be said to 'wear the trousers', who make the major decisions on home management, education, holidays, and finance. 'What mother says goes.' Only those women were included about whose dominance there was no doubt in the minds of the psychiatrist, the P.S.W., and the mother herself.
- (ii) *Dominant*—those women who seem to be the leaders in their homes, to initiate plans, to influence family decisions more than the father, although the father plays a responsible part and is always consulted.
- (iii) *Equal sharing with father*—both father and mother bear an equal amount of responsibility.
- (iv) *Submissive*—the father is clearly the boss and makes all major decisions. Mothers were rated thus only if there was no doubt about their submissiveness in the minds of the psychiatrist, the P.S.W., and the mother herself.

The driving forces underlying the mothers' dominant behaviour appeared to be of four main kinds. First there was what may be called the 'self-punishing', 'driving' kind of dominance illustrated in the cases of Mrs Brown and Mrs Cohen. This appeared to be the result of a need to keep a check on oneself and others—

the dominance of conscience. Women who exerted this kind of dominance often, like Mrs Cohen, deplored the need for their leadership. In some ways they wanted to lean on a strong husband, yet stimulated by their husband's easy-going, permissive ways, their conscience drove them to take over the leadership of the family. Second, there was what might be described as the 'masculine' type of dominance. This kind of dominance was exerted by women who clearly wanted to assume some of the roles of men, who seemed to reject many of their feminine roles and rarely questioned their need to dominate. Third, one could discern a 'maternal' kind of dominance which embraced both aggressive, controlling components and warm maternal elements. Finally, there was the leadership assumed mainly in response to external pressures, such as the husband becoming ill.

These four elements in the pattern of dominance are not presented as rigid, mutually exclusive categories, nor does the dominant behaviour of any particular woman fall clearly into any one category. The types of dominance have been described to indicate the diverse needs that can lead a woman to a dominant role.

Two instances of the driving, conscience-determined kind of dominance have already been observed in Mrs Brown and Mrs Cohen. Noteworthy in both these women were their ambitious drives, their constant criticism of themselves and others alike, and their hardworking, almost self-sacrificing activities, which evoked uneasy feelings of guilt in their families. It is as though they were saying to husband and children, 'I am wearing myself out for you, surely you in turn will play the game and do what I tell you.' Mrs Harris (DU 13) also revealed this type of dominant behaviour. Her father, described as a wise and saintly man, had implanted in her high religious ideals and strict ethical concepts. She mentioned that during her schooldays she had proudly told him how she had found a pretty ribbon and had taken it back immediately to the headmistress. Her father shook his head and replied, 'You are just not a thief.' The adoption of this severe kind of conscience drove her to demand selfless behaviour from herself and her family, who, eventually, rebelled against this almost intolerable pressure in various ways, which will be discussed in later chapters.

Sometimes a much more subtle type of dominance was exercised: One father, whose wife had died before the investigation

began, described her excellence as a manager. He used to give her his pay-packet and she planned the whole of the family spending down to holidays and the buying of his shirts and socks. She had such a 'nice way of telling one the truth'. When criticizing, she would say: 'I know you wouldn't notice, but . . .' and the father added shamefacedly how she always got to the bottom of everything and had found him out in several white lies. This woman, like the others already mentioned, applied the same rigid and exacting standards of behaviour to herself. Her husband said that he would never be able to remarry, as no one else could possibly come up to her standard.

There were several striking examples of women who showed the 'masculine' kind of dominance in which the mothers seemed to reject their feminine role in some respects. One of them was Mrs Booth (DU 14). She had felt happiest when she led a bachelor existence after the dissolution of her first marriage, and regretted her second marriage because it had curtailed her independence and freedom. She persuaded her second husband to buy a house which they could not really afford, and had also encouraged him to go into business on his own, but this had proved too much for him and he had had to give up. At the time of the study she was busy planning to sell the house, and in spite of her considerable domestic responsibilities went out to work full time. The upbringing of her child she had left to the maternal grandmother and serious problems arose when she herself took over the care of her adolescent son, since he would not submit to her driving dominance.

Mrs Fletcher (DU 21), who also displayed this overt 'masculine' dominance, was an extremely bossy and managing business-woman who could never be 'bothered' with housework. She spoke with admiration of her mother who at the age of 21 looked after four apprentices and ran a business with her husband. She stressed that she had brought up her sons to be independent, and indeed to wait on her.

Mrs Cameron (LU 6) from Scotland, already described in the section on psychosomatic disorders (p. 67), exercised a more subtle kind of masculine dominance and ambition. She had initiated the family's move to England, had left her child behind, and stressed that if her husband had refused to make the move, she would have

gone on her own. She managed the family finances; arranged their holidays, and made all the decisions, but she said that she would have liked her husband to share more with her. She preserved a charming feminine poise and outwardly did not give the impression of a managing type of woman.

Mrs Gilbert (DU 3) provided another instance of covert exercise of 'masculine' dominance. She had little interest in home-making and left her husband to do the housework while she went to whist drives. She left the care of her children very largely to the maternal grandmother and always went out to full-time work, remarking to the P.S.W., 'Mind, I did not only go out to work because I had to, but because I liked it.' She had even found her husband's job for him.

The childhood histories of these women provide some clues to the reason for their rejection of feminine roles. Mrs Cameron (DU 6) was the eldest of a large family. Her mother was busy helping with the farm, and Mrs Cameron had had to assume a great deal of responsibility for her siblings, which worried her considerably. She recalled vividly how one brother had cut himself with a scythe, and how she had had to guard her brothers and sisters from the dangers of a nearby bog. Her introduction to feminine and mothering roles had thus been fraught with anxiety and did not appear to her as an enjoyable one. Mrs Fletcher (DU 21), on the other hand, clearly identified herself with her very efficient and masculine mother who lived for her business and had maids to look after the house and children. Two other mothers saw their own mothers suffering very great hardship and anxiety as a result of their fathers' drinking and unkindness. The roles of wife and mother were unlikely to appear to them as particularly joyous or satisfying.

Mrs Foster (DU 22) was probably the most remarkable example of the 'maternal' type of dominance. She had died by the time the study took place, but the sway that she held over husband, family, and village alike was vividly depicted by her husband and daughter. They described her as a large, cheerful woman, radiating warmth and vitality, and an outstanding organizer. During the War she had arranged whist drives for the benefit of 'the boys' in the Forces, and started a fund from which each serviceman from the village received ten shillings every six months. Her

house was always full of friends, she would help anybody, and she was widely respected in the neighbourhood. She managed the family affairs, did the punishing of the children, and had married a man who was considered a 'poor fish' by the rest of the family. He had 'to do as mother told him', and the family remarked that 'there was no room for two like that'. They commented on the way the garden had been neglected since the mother's death, and the eldest daughter turned to her father, saying, 'Mother would have sent you out with a spade'. This daughter had by that time taken over the role of dominant mother in the family. These maternally dominant women seemed to have a large reserve of unused maternal feelings, and in general were grossly over-protective towards and possessive of their children, a tendency which will be discussed in greater detail in the next section. They closely resembled the over-protective type of mother described by David Levy (1943, pp. 157-8).

In some families the father's illness, increasing dependence, or lack of interest in the home had forced the mothers to take over the leadership of the family. It is, however, quite possible that these women could not have responded so well to the challenge of circumstances if they had not found the corresponding wishes within themselves, as the following example suggests.

Mrs Armstrong (p. 23) described herself as an easy-going, affectionate woman who brought up her family in the rough friendliness of a Durham mining village. The father was said to be the unquestioned head of the household. Her son gave a similar picture to the psychiatrist. In recent years the father had developed bronchial trouble and was eventually invalided from his work. As he became more of a confirmed invalid and dependent, so the mother increasingly took over the leadership of the family. She became an overpowering, critical mother, constantly 'coming up with advice', as her son put it. When the family had to leave their tied house she took up the struggle with the housing authorities and organized the move. She was the man about the house, and also went out to work, did the gardening, and seemed to have inexhaustible energies. The father accepted her leadership placidly. On one occasion she said, 'I shall have to go out and find him a job.' She realized that

the father was capable of some useful occupation and might for example do the shopping while she was at work, but she found it impossible to let him do even that: 'He would not know what to get.' Her managing dominance was also evident in her relations with the P.S.W. When the latter sat down in a different chair from the one she sat in on her previous visits the mother said in a friendly, but determined way, 'This is yours . . .' It was difficult to believe that this competent and energetic woman did not have the potentialities of leadership in her which she was able to develop to the full in response to the challenge of external circumstances.

In another family it was possible to observe a different process of a gradual response in a rather gentle but ambitious mother to her husband's need to recreate in her the powerful mother-figure of his childhood.¹

The control sample contained fewer dominant women (10). Moreover, although the various kinds of dominance were observable, only the self-punishing 'conscience-driven' women on the one hand, and the 'maternally' dominant mothers on the other, stood out clearly.

Mrs Bradshaw (C 7) wore herself out looking after a dependent and semi-invalid husband. She took and carried out the decisions on all matters from budgeting to house decorating. Mrs Blake (C 3) dominated by means of a kind of nagging prudishness. Mrs Briggs (C 12), a striking example of extreme self-sacrifice and incessant hard work, supported her family and a permanently sick husband. She too was a woman who had risen to the challenge of external circumstances, which at the same time had satisfied many of her inner needs. Mrs Atkins (C 14) was an efficient woman who, exasperated by a drifting and ineffectual husband, separated from him, and became the hardworking, highly successful organizer of a large W.V.S. canteen. Her dominance contained both 'conscience drive' and marked masculine elements. She was extremely independent and efficient in the management of her own affairs and never contemplated a second marriage.

The maternally dominant women in the control sample were intelligent, warm, and efficient mothers who tended to treat their

¹ This case is discussed more fully in relation to the father's problems on page 119.

husbands as children and were clearly their intellectual superiors. Mrs Gates's (C 15) dominance, for instance, was quite apparent even on the first visit. Although both her nineteen-year-old son and her husband were present she took complete charge of the situation. She took her son's cooperation in the research for granted and hardly bothered to consult him. When the father tried to join in the conversation by inquiring whether fathers were to be interviewed, the mother brushed him aside like a child who had spoken out of turn. Mrs Gates also tried to take motherly charge of the P.S.W., seeking to put her at her ease and commenting on how difficult she thought it must be for her to approach strangers.

At this point it is pertinent to examine the effect that these dominant and neurotic mothers in the control sample had had on the health of their sons. Two of the sons had recently complained of indigestion, though neither had been examined to see if they had ulcers. Two more had skin complaints. Another two, although in their middle twenties, showed no signs of being interested in girls. The rest were in considerable conflict with their mothers over the problem of emancipating themselves from their influence, but seemed to have a greater ability to 'fight back' than their counterparts in the DU sample.

The four families in the DU sample where the father was considered 'to be the boss' presented a sharp contrast to those in which the mother was dominant. In two of these families, the fathers were ambitious, striving individuals with a great deal of initiative, who had achieved responsible positions at work. They had duodenal ulcers. The third, who frequently expressed the idea that there 'could only be one governor' in the home and expected to be obeyed by his grown-up sons, suffered from recurrent dyspepsia. In the fourth family, the father was described as a benign autocrat who made all the decisions, while the mother took the part of the little girl and referred to herself as 'soft and silly'. All four mothers in these families were somewhat softer, less forceful and less exacting than the general run of mothers in the DU sample. The control and dominance that the mothers exerted in most DU families was exercised by the father.

Only two families in the DU sample conveyed an impression of

genuine equal sharing of responsibilities between husband and wife. Mrs Castle (DU 24) gave convincing accounts of fifty-fifty sharing with her husband in most decisions and experiences, and Mrs Bright (DU 25) provided equally convincing evidence of give-and-take, cooperation, and decisions reached through discussion. In the two other families that appear in the table as instances of equal sharing, an uneasy compromise had been achieved in which the father and mother pulled in different directions, going ultimately their own ways, with neither dominating the other.

When we come to consider the cases of equal sharing in the control sample (I4), the picture is different, and we find repeated evidence of flexible cooperation. Mrs Hammond (C 11) related how her husband arranged his fortnight's holiday to help look after her and the family at the time of her confinements. They respected each other's independence over their earnings. The mother saw to the behaviour of the children, but they looked to their father for final decisions on big issues. Likewise Mrs Brewer (C 9) described how she and her husband fell in with each other's wishes, while their son said, 'There is no boss, they try to please each other.' In another family, the father called the marriage a 'fifty-fifty partnership'; decisions on all important matters were shared, and 'nobody could say who was the boss'. But, as in the DU sample, there were some families in which neither parent was dominant. This 'equality' did not arise from cooperation and the joint acceptance of responsibilities, but from an uneasy compromise between conflicting aims.

There was still a good deal of sharing and consultation in the six families classified as 'mother-submissive', and, in contrast to the DU sample, no instances were encountered of fathers who ruled through driving ambition. There were, however, several aggressive fathers who 'ruled the roost', like Mr Butcher (C 10), a heavy drinker, who indicated in no uncertain manner when the meals should be on the table, what time the children should go to bed, and where they should spend their holidays.

The general tendency in the DU sample for the mother to be the dominant person and wield authority appears to be an exaggeration of trends established in other studies of urban society. Thus Robb remarks:

'... School teachers, social workers, and others who have contact with Bethnal Green families, nearly always agree that the real head of the family is the mother, but a few stress the importance of the man as the final authority. This disagreement seems to be based on a sharp division of labour between the man and woman, and a difference of opinion as to which role is to be regarded as the more important.' Because of the crucial nature of his rôle as breadwinner, 'the father tends to get first consideration in the comforts and amenities of the home. On the other hand his abdication from responsibility for activities within the home leaves his wife in a central position as far as closer relationships within the household are concerned.' (Robb 1954, p. 60).

Gorer (1955, p. 170) found that three-fifths of English parents think the father should be the chief source of authority in the home and one third the mother. This proportion is nearly identical with the proportion of 'dominant' mothers in the Control sample. He also found that mothers appear to have more authority in the big towns than in the rest of the country.

This trend towards maternal dominance needs to be seen against the background of the changing roles of women in our society. Since men are out of the home so much—Margaret Mead has called the American father 'the tired nightly visitor'—women in many sections of society have taken on some responsibilities that formerly were probably carried out by their husbands or shared with them. For example, it was the rule in both samples for the mothers to pay the rent and other quarterly or monthly bills. They often acted as chancellors of the family exchequer and organized the saving for holidays and other special treats (Zweig, 1948;¹ 1952, especially pp. 72–75). The gradual emancipation of women apparent in the right to vote, in their entry to most professions, and in their eligibility for an education similar to that

¹ '... in the majority of cases the husband's money is clearly divided into two parts, with clearly defined obligations incurred by them. Out of her allowance the housewife nearly always pays the rent, light and heat, food consumed at home, all school meals, all clothes for herself and the children, and her own; and the children's outings. Her husband's pocket money goes on fares, food out, cigarettes, drink, amusements and other pleasures, his own clothes, sometimes also his savings. But of course the line of division is not always clearly defined, and there is give and take on both sides' (Zweig, 1948, p. 12).

available to boys, is a very recent development, and one that gives them a feeling of equality and rivalry with men; whereas the cultivation of their unique contribution to our civilization is relatively neglected. In particular, girls are ill prepared for marriage, parenthood, and the arts of home-making. Indeed there is a current devaluation of home-making activities—'the drudgery of the kitchen sink'. As Iago Galdston said dramatically at the Conference of the American Psychiatric Association in 1952:

'One after another of woman's functions, of her utilities in the home have been taken from her, first by the machine, then also by the mercantile, commercial and social agencies. Now she neither spins nor weaves, she has neither greens nor herb garden. She does not bake, though she may yet cook, in a word as some feminist and liberal friends say eagerly, she has been freed from the yoke of household chores. She is a free woman! 'Free for what?' he asks, and he concludes that: 'Woman, so largely deprived of her God-given prerogative is seeking retribution in a frenzy of aggressions and frustrations' (Galdston, 1953).

This seems a somewhat exaggerated American view of the situation, but it is likely that at the present time women, and especially the more capable and active ones, have a reservoir of unused potentialities that might lead them to exercise more moral leadership in the home than the circumstances warrant. This may be particularly so in middle age, when the children have grown up while the women are still relatively youthful, the time-span of child-rearing being much shorter now than it used to be when families were larger. Under these conditions women might even fancy themselves more important than they are. (In several families the mother painted the father as a 'poor fish' who would not have anything to say for himself, while in reality the father was an intelligent and decisive man.) Thus, in so far as maternal dominance in the home reflects the explicit assumption of greater and different responsibilities in place of old ones, and in so far as it represents a reservoir of freed but as yet unused energy, it seems to be a healthy sign of change and development in the roles of men and women in society. Eventually men and women may become adjusted to the rapid changes taking place in our kind of society,

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not by aiming at competitive 'equality' but by using their different gifts in complementary ways and by 'cultivating in each sex their special superiorities' (Mead, 1949, p. 382). In so far as female dominance in the home represents a neurotic need, born of frustration, to restrict and rob men of their maleness, it is a disquietening phenomenon, which warrants much further study.

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CHAPTER V

The Mothers' Attitudes to the Upbringing of their Children.

In the discussion so far of the DU mothers' personalities, it emerged that about two-thirds of them were dominant, efficient women, that many showed marked obsessional characteristics, and that there was a strong tendency towards psychosomatic symptoms. In contrast it was found that the mothers in the control sample were less dominant, showed hardly any tendencies towards psychosomatic disorders, and that their obsessional preoccupations were also considerably less. However, the amount of neurosis found was the same for both groups of mothers.

In discussing their personalities and activities, terms such as 'anxious', 'protective', 'controlling', 'conscientious care', etc. were often used. One of the stated hypotheses was that mothers in the DU sample take more special care and exhibit more 'worry' and 'fuss' in the upbringing of their children than do mothers in the control sample. This kind of anxious protectiveness was described in the detailed case studies. Mrs Cohen, in particular, was an outstanding example of this, as was seen in her continuous rounds of hospitals with Michael, and in her meticulous attention to his legs, to his school-work, and latterly to his diet. The other two mothers also took special care, but in quite different ways: Mrs Allen in excessive indulgence, in an inability to say 'no' to any demands her child made; and Mrs Brown in a kind of restrictiveness which drove her to exercise a great deal of control over her child's activities, to probe, to criticize, and to nag. The behaviour of these three mothers seemed to have one basic aim in common, a desire, of which they were unaware, or only partly aware, to keep their children dependent on them. In the interpretative comments, some of the reasons for this wish to keep the child close were sought and it was found that they appeared to spring from

complex, unconscious forces which had their roots in the mother's own relationship to her parents. These attitudes of protectiveness, over-indulgence, and restrictiveness described in the three case studies interact and cannot always be clearly distinguished from each other in any one case. For example, Mrs Cohen's own childhood insecurities and other anxieties drove her to protect Michael. Her need to dominate, to control, and to set high standards of behaviour for herself and others, caused her to restrict and supervise him excessively and to exert constant pressures; and her own deprivations in her youth led her to indulge him, to give him the things she did not have, particularly good food and home comforts.

The attitudes of protection, indulgence, and restrictiveness that were observed in an exaggerated form in these three mothers are basic to maternal care: the mother needs to protect her young against the dangers of the outside world if they are to survive. She needs to indulge and gratify their instinctual needs for food and love if they are to develop physically and emotionally, and to train her children and gradually control instinctual expression if they are to develop socially. Conflicts are bound to arise if mothers protect their children excessively because they are then less able to develop the resistance necessary to cope with the harshness of the outside world when they are ready to leave the nest. Similarly, difficulties will occur if mothers over-indulge their children because, not having learnt to 'do without', they will remain immature, demanding children. Complications may also result from the mothers' restrictive control, which tends to inhibit emotional expression and particularly aggressive drives. Their children may become emotionally constricted, unable to stand up for themselves and to fight for what they want or believe in, and also unable to express freely their loving feelings and thus evoke a response in others.

The operational definitions employed in rating mothers for attitudes of restrictiveness, anxious protectiveness, and over-indulgence are as follows:

The mother's *restrictiveness* is an expression of her need to control her environment and to mould her child to a preconceived pattern. This restrictiveness can be manifested in *external control* by restricting the child's activities and particularly the expression

of aggression, for example by discouraging outside activities, by supervising friendships, or by choosing his friends herself. It can also be a kind of *internal control*, a watchful conscience, which is manifested in stressing discipline and in exerting constant pressure in the direction of training, good behaviour, tidiness, cleanliness, and achievement generally. These pressures, which are often very subtle, emanate from the mothers' highly developed conscience, which urges them to demand high standards of conduct from themselves and from their sons with whom they are so much identified. In this context, Peter's statement, 'Mother always seems to be pushing me from behind', will be remembered. By *ordinary control* is meant the exercise of firmness and discipline, for example about mealtimes, sleep, and reasonable tidiness, without the tendency to restrict activities unduly or to exert constant pressure. A mother exercising this kind of control will allow her child to mix freely with other children, or to deviate occasionally from the ordinary routine. By *lack of control* is meant an absence of attempts to train the child or supervise his activities. The child may be allowed to run wild, and there is little 'supportive' routine as regards mealtimes, sleep, and play.

While restrictiveness may be thought of as a defence against instinctual urges from within, such as aggression, protectiveness may be regarded as a defence against dangers from without; thus *anxious protectiveness* can manifest itself in many spheres in which the mother feels it necessary to protect her child against dangerous influences, real or imaginary. It can often be observed in the sphere of play where children may need to be protected against the influence of other companions and the dangers of playgrounds, streets, etc., and it may be sensed in the mothers' cautious concern over all the child's activities. It can be seen very clearly in protective acts which are quite inappropriate to the child's age, i.e. dressing or feeding him when he is old enough to do so himself. Attitudes were rated *normally protective* when they showed no evidence on the one hand of over-anxiety regarding health, play, or other activities, and on the other of neglect to carry out protective functions, and where the child was allowed to take reasonable risks. Attitudes were rated as revealing *lack of protectiveness* when the child was deprived of ordinary maternal care by being left to fend for himself, or to get his own food.

Indulgence is the ability in a mother to give, to gratify the child's needs both materially and emotionally. *Over-indulgence* can be expressed in extreme generosity and in a compulsive need to give to the child almost irrespective of his actual needs, and conversely in an inability to deny him anything or to frustrate him. Often the son who has been over-indulged feels in later life that he has 'had everything he wanted', that things have been arranged to 'drop into his lap', or he feels strongly that he has been 'spoiled'. The rating *normal indulgence* was applied to the kind of mother-child relationship in which there was evidence of affection, generosity, and a 'giving' attitude that related to the child's rather than to the mother's needs, combined with an ability to say 'no', if necessary. *Lack of indulgence* marks a mother-child relationship in which the mother appeared to deny affection and frustrated the child unnecessarily either materially, by providing the bare minimum that he required, or emotionally, by withholding affection or making it dependent on certain conditions.

Although these three attitudes are psychologically interrelated and may perhaps loosely be brought together under the concept of *maternal possessiveness*, it is helpful to consider each of them separately for purposes of comparison, more especially because each is derived from a different maternal function that can have different effects on the growing child and adult. Moreover, there were only 3 mothers in the DU sample who, like Mrs Cohen, revealed all three attitudes, while 22 displayed one or two of these attitudes, but not all three together. For instance, some mothers were predominantly protective but not especially restrictive or over-indulgent, others were over-indulgent while not being particularly protective, and so on. As would be expected, there is a considerable overlap between the anxiously protective and the restrictive mother (eight are both), for the anxiety to protect the child from dangers can lead to a great deal of control and restrictiveness. However, they need not go together. One of the very protective mothers, Mrs Fry (DU 16), who is described later, though continually striving to protect her child from external dangers, did not feel impelled to control him closely, to nag him about his behaviour, or to push him continuously as most restrictive mothers were apt to do. There is also considerable overlap

between restrictiveness and lack of indulgence, because, as the case of Mrs Brown showed, the mother who is preoccupied with success and who is critical may find it difficult to give affection unconditionally. But restrictiveness need not necessarily go with lack of indulgence. Mrs Cohen was both restrictive and indulgent, and on the other hand there were several mothers who neither indulged their children, nor bothered to control them. Again, although the term over-indulgence is often used in every-day speech to indicate the opposite of restrictiveness, in this study these two attitudes were not true antitheses of each other. Indeed it is one of the characteristics of DU mothers that though conscientious and restrictive they are, at the same time, generous givers of material things; and while they may find it difficult to tolerate aggressive drives, they are often able to gratify adequately the child's needs for material comfort and love.

Table 9

MOTHERS' PROTECTIVENESS

	DU	Control
Anxious protectiveness	14	7
'Normal' protectiveness	12	22
Lack of protectiveness	6	2
Unknown	0	1
Total	32	32

The table shows some differences between the two samples in regard to both the positive and negative poles of protectiveness. One of the most striking examples in the DU group was Mrs Fry (DU16) who dressed and fed her son until he was 5 and rocked him to sleep for many years during childhood. She could not bear him out of her sight, as she imagined that danger would befall him. He was not allowed farther than the front gate until he was 8 years old, when his school teacher persuaded the mother to let him venture a little farther. As luck would have it, when he did play on a swing in a playground later on he had a serious accident which led to concussion. Her over-protective attitudes were observable at the time of the study in relation to her youngest child, a boy aged 9. She displayed great concern about possible germs in the exchanged comics he brought into the

house, and about his climbing walls and injuring himself while collecting conkers. The overall result of her protectiveness, her readiness to wait on her children and keep them dependent, was seen when she went on holiday. She had left all kinds of ready-cooked food in the larder for her two grown-up children (our patient and his older sister). When she returned the food had gone bad and was untouched—they had not bothered to get themselves a single meal.

There was also the mother whose protectiveness was called forth by her child's serious illness and who was later unable to abandon her over-protective attitude. Mrs Fletcher's (DU 21) son had a slight attack of polio which kept him in bed for three months and from which he recovered completely. Subsequently he was not allowed to play games, and in the mother's own words, she 'did not let the wind blow on him'. When he was in the Army, she arranged for him to have meals at the best hotel in the town in which he was stationed. (It is not surprising that the rough-and-tumble of the Forces proved an unendurable experience for this boy.) There were other mothers whose long-standing protectiveness only became apparent in their present behaviour. For instance, when Mrs Bright (DU 25) was in hospital for an operation, her son missed his appointments with the psychiatrist because, it turned out, she had always reminded him. Her husband took this opportunity to tell her that her son would now 'have to learn to stand on his own feet'. It was only then that she admitted that she had always been rather inclined to 'do things for the children'. Another mother, Mrs Harris (DU 13), seriously considered going to Manchester to inspect the suitability of the lodgings her son was to take on entering the university. The mother's tendency to make herself indispensable is quite clear in these examples. They did not contemplate that their growing sons would be able to cope with the playground, the rough meals in the Army, the keeping of appointments, or the finding of suitable accommodation away from home. One DU patient remarked that his mother 'looks after me too well, as though I was a baby'.

As the table shows, there were over-protective mothers in the control sample, but most of them seemed more able to let their children grow out of their dependence and curb their own

protective drives as the children grew older. This was particularly evident in the case of Mrs Bull (C 17), who had to hold her child's hand while he went to sleep up to the time he was 5 years old. She had never considered the possibility of evacuation during the War as she could not visualize any separation. When he attended a scout camp at the age of 11 he wrote very unhappy letters home and the mother struggled with her desire to tell him to come home or to fetch him herself. Finally she let him stay for the fortnight, after which he began to mix more freely with other boys, and she was able to tolerate his growing independence. Mrs Cox (C 8), a severely obsessional woman (Appendix II, p. 267), said that she had always 'spoon-fed' her children; she bathed her son until adolescence, and still cleaned his ears and washed his neck on occasion. Again, her protectiveness had not the all-pervading quality of the DU mothers' protectiveness. It was confined to the boy's body, as it were. In other respects she was able to let him lead an independent adult life. Mrs Hodges (C 2) was protective of her son as he had been delicate in childhood and had had what sounded like epileptic fits. She, in contrast to Mrs Fletcher (DU 21), was able to relinquish her protective activities when they were no longer necessary. At the time of contact this young man was leading a strenuous and adventurous life working away from home as a steel-erector, and his mother was unworried about his hectic and roaming existence. There was also an interesting difference in the mother-son relationship later on. Whereas most of the over-protected DU sons reacted by some kind of withdrawal and secretiveness as Peter and Michael had done, the three young men in the control sample just described who had been over-protected, preserved a close and spontaneous relationship with their mothers, and talked things over with them eagerly. On the other hand, the sons of Mrs Harris (DU 13), Mrs Fry (DU 16), and Mrs Fletcher (DU 21) were rather secretive and their relationships with their mothers were strained.

The table shows also that more mothers (6) lacked protective attitudes in the DU than in the control sample (2). These mothers, who had difficult or broken marital relationships and suffered from neurotic or psychosomatic tendencies, were unable to show warm, consistently protective attitudes towards their sons and can be said to have neglected them in various ways. Mrs Gilbert

(DU 3), a depressed woman (Appendix II, p. 264) who received little support from her husband, went out to work when her son was two months old. The son was acutely aware later on of having missed the ordinary comforts and loving care other children enjoy. He often had to get his own tea, and light the fire, etc. on coming home from school. Three more mothers lacking in protective attitudes have already been described in the discussion on psychosomatic disorders (p. 65). Mrs Clayton (DU 8) deserted her children at a difficult stage in her married life and her son was admitted to a children's home for a time when he was 9 years old. He stated in his interviews with the psychiatrist that he had never forgiven her for this desertion. Mrs Davies (DU 9) was unhappily married to a husband who drank and was unhelpful. She believed in letting her children fight their own battles, and seemed genuinely ignorant of certain crucial episodes in her son's life. In his interviews with the psychiatrist the son complained about the lack of tidiness and comfort in his home, and added that his mother did not bother about his diet—such neglect being an extremely rare occurrence among DU mothers. Mrs Cross (DU 7) was a markedly immature woman, who left her husband when her baby was 5 months old and delegated the care of her baby to her own mother. The grandmother was an alcoholic and very erratic in her handling of this boy who never experienced security during his childhood. The fifth case of lack of protectiveness in the DU sample was a very severe one. Mrs Dale (DU 18) (described in Appendix II, p. 263) was a woman bordering on the psychotic. She suffered from the delusion that her son was not her child at all, and consistently refused to care for him in the way she cared for her other children. There was, finally, Mrs Farmer (DU 26), a paternal aunt who, together with the paternal grandmother, took charge of her brother's illegitimate child and brought him up in a rough-and-ready way; he had to fend for himself a good deal. Most of these boys were aware of the lack of protection they had experienced, and in later life showed barely concealed longings to be 'looked after'.

In contrast, only two mothers in the control sample were rated as lacking ordinary maternal protectiveness. Both showed characteristics similar to the non-protective mothers in the DU sample. They had difficult marital relationships, suffered from neurotic

disturbances, and showed signs of partial rejection of their children. Mrs Dobson (c 6) left her baby in an isolation hospital for 9 months with whooping cough, and never inquired into the cause for his prolonged stay. She left him again to fend for himself in lodgings as a young adolescent during the War, while she followed her husband—a chronic alcoholic who needed her support—to a town in the West Country. Mrs Bailey (c 4) had had her child before marriage. He was minded by various people and had to fend for himself all his life. This mother never attempted to conceal her dislike of children, and was unable to 'fuss or cuddle them'. She sent her child to school when he was ill, saying, 'They can look after him better than I can.' Both these young men felt bitter about their mothers, with whom they had a very strained relationship.

Finally, a possible yardstick of the greater care and absorbed attention which the mothers in the DU sample gave to their children is the number who refrained from going out to work. Twenty-five, as against 14 in the control sample, did not go out to work at all before their sons had reached 10 years of age. As the families in the DU sample were similar in size and from the same social classes, this phenomenon is a remarkable one, and perhaps the most significant external index of the differences in the mothers' attitudes. Moreover, going out to work tended to be associated with lack of protectiveness in the DU sample, but not in the control sample. Three of the 7 mothers in the DU sample who went out to work were rated outright as 'non-protective'. Two more, though not rated as non-protective, deliberately turned to full-time work outside the home when their sons were still very young and delegated their care entirely to their grandmothers. Only two of the working mothers in the DU sample seemed to have combined work with reasonable maternal care.

The attitudes of the working mothers in the control sample were very different. With the exception of the two rejecting mothers already mentioned—Mrs Dobson (c 6) and Mrs Bailey (c 4)—who were lacking in protective feelings, they seemed able to combine work outside the home with a warm and reasonably protective relationship to their children. This is confirmed by the patients' and control subjects' comments about their mothers.

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Whereas the DU sons of working mothers often complained about the lack of maternal care and felt neglected, in the control sample only the sons of Mrs Dobson and Mrs Bailey did so. The others seemed able to accept their mothers' work and appeared to feel that they had obtained their share of love and affection, and that their home lives ran a smooth and happy course. (It is of course possible that because of his strong oral demands, which will be discussed below, the DU patient has a greater need for maternal care, and is therefore less able to tolerate other activities on the part of his mother.) It seemed as though the mothers in the control sample were better able to give expression to diverse aspects of their natures and had far less of an 'either or' attitude than the mothers in the DU sample. They seemed able to apply their energies to a wider range of activities and perhaps for this reason they were less intense and possessive with their children. They appeared to take things as they came, and were able to compromise and improvise as occasion demanded. Many of the mothers in the DU sample seemed dimly aware of this situation and often they would say something along these lines: 'We have protected our child, we have taken great care about his health, his sleeping arrangements, his leisure activities, his education, yet he has developed this illness. Now, there is Johnny Smith next door, he has had to rough it, had poor clothes, was out in all weathers, his mother had to go out to work and was not able to look after him as carefully as I did, and yet he seems to be tougher, happier, and healthier than my boy.'

Table 10

MOTHERS' INDULGENCE

	DU	Control
Over-indulgence	12	5
'Normal' indulgence	13	25
Lack of indulgence	7	2
Total	32	32

Not only were there more over-indulgent mothers in the DU than in the control sample, but also more non-indulgent mothers. In the DU sample the mothers expressed their over-indulgence most clearly in matters relating to food. There were also a few who, like Mrs Allen, had an almost compulsive need to give

presents to their sons. The most extreme example was Mrs Anderson (DU 27) whose son received whatever he wanted from either his mother or his grandmother so that his greed knew literally no bounds. The mother reported that he was a hungry, greedy baby and that later she used to put some food beside his bed at night. As he grew up his 'hunger' extended to other activities. He quickly tired of a toy and would demand a different one. His wife complained of his excessive sexual demands. Though in his early twenties and renting a comfortable, spacious flat, he did not rest until he obtained a house. Having got the house, he worked like a Trojan in his garden to produce the greatest show in the neighbourhood in the shortest time possible. He told the psychiatrist that in childhood he had had everything he wanted and was made 'selfish', and that he felt overpowered by his mother's generosity. Mrs Foster (DU 22), already quoted as an example of maternal dominance (p. 75), was another over-indulgent mother who kept her son at the breast for two years and always had some special food waiting for him, to the envy of her eldest daughter. When this boy was away on holiday he would spend all his pocket money on buns and sweets. The stories this young man told when he did Murray's Thematic Apperception Test contained references to his guilt at 'having had things too easy'. Mrs Ellis (DU 19) like Mrs Allen had a compulsion to give to her child. She often talked about the expensive shirts and other large presents she bought him and how she felt that she *had* to do these things. She claimed that she was only going out to work in order to be able to buy additional luxuries for her son. She said that she was unable to refuse him anything. Her slogan was that 'children should have all they want', and she added that in her opinion juvenile delinquency was due to children not getting enough gifts and money from their parents. This mother had felt disgusted and embarrassed over breast-feeding her baby and sometimes let him wait for hours. The element of reparation in her giving seems clear.

The kind of indulgence in which the mother not only lets the child have anything he wants but is actually controlled by the child, was not met with in the DU sample (Levy, 1943, pp. 100-11). Although they were very indulgent in many respects the three mothers just described still retained control over their

children. Mrs Anderson (DU 27) was said by her son to have brought him up strictly and he mentioned that he 'had to do things when I was told'. Mrs Ellis (DU 19) had strong views on bad language and manners which she was able to impose, and Mrs Foster (DU 22), though not a consistent disciplinarian, was impatient to have things 'done her way' and was as generous with her slaps as with her affectionate remorse afterwards.

None of the six cases of over-indulgence in the control sample were as extreme as those described in the DU sample. These mothers were very easy-going women who gave in to their children readily, used to wait on them, and gave them the best of everything. Like their opposite numbers among the DU patients, several of the young men commented somewhat uneasily on the 'spoiling' they had received and betrayed resentment at their mothers' overpowering generosity. All of them had preserved fairly close ties with their mothers.

Seven mothers in the DU sample showed marked lack of indulgence. Mrs Gilbert (DU 3) was unable to express affection and her son commented that he could never remember having received affection from her. Similarly, Mrs Cross (DU 7) always remained remote from her child 'like a visiting aunt' and her son complained that he could 'never get close to her'. His grandmother who brought him up was impatient and 'never had time to listen'. Both Mrs Gilbert and Mrs Cross were also lacking in protectiveness. Two more of the 7 'under-indulged' children were 'starved' of maternal care in this way and they showed intense longings to be looked after in later life. Three of the four married young. The other three mothers combined lack of indulgence with normal protectiveness. Mrs Brown, who was unable to express warm affection, brought Peter up with the greatest care. Mrs Harris (DU 13), another conscientious mother, gave with one hand and took away with the other. She gave her son his pocket money, but would then point out that there was a poor child in his class who had not got a copybook, and that it would be nice to buy him one with the pocket money. Mrs Bennett (DU 15), a most meticulous mother as regards material care, seemed incapable of responding warmly or generously to her son's emotional needs. The two mothers in the control sample who were lacking in indulgence, had similar ways of behaving. One mother

belonged to the ranks of those who lacked maternal feelings generally, and one to those who make their indulgence depend on 'good behaviour'.

While the DU mothers' protective activities could be understood in terms of their conscientious, careful controlling personalities, the springs of indulgence seem more obscure and diffuse. There were some mothers in both samples who seemed to have an abundance of maternal feelings, but most mothers seemed to have had different unconscious motives for their over-indulgence. Some, like Mrs Allen, had overtly or covertly shown signs of rejection, and their indulgence seemed to be an attempt to make up for this. Another factor, however, was revealed in the DU mother's remark about delinquency—an element of bribery, a deep fear that unless one gave in to the demands of the child revenge in the shape of aggressive or delinquent activities might follow. Conversely, the non-indulgent mothers seemed to fear that if they indulged their children this would foster the growth of undesirable instinctual forces such as aggression. This attitude of non-indulgence is, as mentioned before, closely related to the attitude of restrictiveness (five of the non-indulgent mothers were also restrictive), which will now be discussed.

Table 11 MOTHERS' RESTRICTIVENESS

	DU	Control
Restrictive attitudes	14	3
'Normal' control	14	27
Lack of control	4	2
Total	32	32

The difference in restrictive attitudes between the mothers in the DU and in the control sample is a striking and important one. This need to restrict and control relates clearly to the DU mothers' driving dominance and obsessionalism, to their conscientiousness and high standards of behaviour. It is likely that the number of restrictive mothers is actually an underestimate because their controlling and restricting activities were infinitely subtle and often cloaked by an apparent attitude of letting their children enjoy a good deal of freedom. In some cases the restrictive

attitudes were only revealed after prolonged contact and observed in the contemporary situation; no definite evidence could be obtained on the mother's behaviour during the son's childhood, and for this reason these mothers were not rated as restrictive.

The mothers expressed their restrictiveness in many different ways. When her boy began to toddle around, Mrs Austin (DU 2) decided to institute a strict régime of control. She went to considerable trouble in seeing that her prohibitions were always carried out. If she told the child not to play with water, she would be around to see that he did not turn on the tap. She felt that most parents did not trouble to ensure that children carried out their requests and thus had no control over their children. She was never actively unkind; she would 'reason' with her child and give him a little cuddle whenever he wanted it. She felt a special need to curb his aggressive and creative urges. When very small he started scribbling, drawing, and painting, and as he grew up he became an artist of considerable promise. The mother resented the untidiness that always surrounded his activities and the freedom with which he expressed himself. From time to time she would have a complete clear-out, throwing away his pencils and his paintings, even the bits of paper on which he had done sketches. Although she later learnt to value his gifts intellectually, she has never found herself in sympathy with his free artistic creations. Like Mrs Brown, she was always anxious to find out what was going on inside her son and if he was 'bottling things up' she would apply the cork-screw to dig it out of him'. The patient told the psychiatrist that at home there was a tendency to 'clamp down'. When he was away on holiday he would relax and 'let things go by the board'. He felt his mother was overwhelming, curtailng, and tried 'to arrange everything so that it fell into my lap'. He praised her food, adding that she never gave him any food he did not like. Here again is a mother who exercised stern control over aggression, and yet generously satisfied her son's needs for food and material comforts.

Mrs Booth (DU 14), another very obsessional, competent and dominant woman, felt exceedingly exasperated by the slow and slapdash ways of her son, who had been greatly indulged in his early childhood by the maternal grandmother who brought him

up. She was continually criticizing him and admonishing him to be cleaner, tidier, and smarter generally and insisted that he must learn to 'toe the line' and tolerate criticism. She, like Mrs Brown, was ambitious for her son and tried to spur him on to far greater efforts than he was capable of. Eventually, unable to stand the pressure any longer, he left home (see p. 168).

The desire of Mrs Bell (DU 28) to keep her boy close to her was very apparent. She proudly related that her son never wanted to go out to eat or play at his friends' houses, but always preferred his mother's food and his own garden. She quoted his childish saying of 'wanting to marry Mummy' with much pleasure. She felt sure that following her husband's death he intended to look after her and she was intensely surprised and upset when he decided to marry. Serious problems arose between the mother and the daughter-in-law.

Finally there were the mothers who were wedded to firm routines from which they never deviated, whether in connection with potting, cleanliness, mealtimes, or modes of living, such as the pursuit of 'respectability'. For example, Mrs Bennett (DU 15), already mentioned as a non-indulgent mother, kept to a strict routine of early bed and meticulous changing of 'school' and 'home' clothes until her son started work. At seventeen he handed over his whole wage packet and she bought his clothes and gave him pocket money, whereas the less restrictive mothers encouraged gradual independence in the handling by their sons of their own money. The boy felt that his mother was 'always asking me to do this or that'; that she was strict and punishing, that she 'dominated everything' and that her aim was to be 'respectable' at all costs.

All these varied restrictive activities seemed designed to mould the child in a certain way in accordance with the mother's ideals rather than with regard to the child's own individual needs.

Four mothers in the control sample were rated as having attitudes of restrictiveness but only one showed the all-pervading restrictiveness just described. The activities of the other three were less in the nature of a general and deliberate training and moulding process than a concern with particular matters such as excessive control over messiness in the house or late hours. Similarly, fewer mothers in the control sample expressed ambitious strivings for

their sons in terms of their own ideals. Eight of them, compared with twice that number in the DU sample, showed clear evidence of ambitious strivings, educational or vocational, for their children. On the whole the mothers in the control sample were much more 'easy-going'. Children were allowed to roam and find things out for themselves. If mothers were strict in some ways, for example about homework, they would display tolerance and latitude as regards leisure activities and friends. Some mothers expressed the idea that they wanted their children to experiment and learn by their own mistakes, and many seemed able to let their children engage in activities away from home without having to probe and know all about their experiences. The mothers in the DU sample, in contrast, showed an overwhelming need to probe into their sons' activities, which represents yet another form of subtle control.

In both samples there were only six mothers who showed a conspicuous lack of control and four of these were also lacking in protectiveness. The most interesting exception was a very maternal, indulgent mother of a large family who said that she would have liked to have twenty children. Her lack of control was felt acutely by the patient himself, who thought that his mother had not been strict enough. He recounted how he could come in at any time and do as he liked, and how little there was of set routine in the home. It is understandable that this laxity on the part of the mother, which was coupled with the opposite attitudes of strictness on the part of the father, created many problems for the boy, who drifted from job to job for a time, and was finally thrown out of the house by his father who could not tolerate the boy flouting his authority.

In the control sample, Mrs Bailey (C 4) has already been described as the neglectful mother of an illegitimate child who prided herself on having no set routine, and on allowing the children to eat when they liked, go to bed when they liked, and roam the streets at all hours of the day or night. The second mother in the control sample was a depressed, ineffective little woman, whose boy used to truant persistently from school. She seemed unable to exercise any kind of control.

In all, two-thirds of the mothers (22) in the DU sample showed to varying extents the attributes of 'maternal possessiveness' that

were defined at the beginning of the chapter.¹ More than one-third were either anxiously protective or over-indulgent, and nearly one-half were restrictive in their attitudes towards their children. Some of the combinations in which these attitudes actually occurred in a single mother have been discussed.

In the control sample only one-third of the mothers (11) showed any of the three attitudes described, either singly or in combination. An interesting difference between the samples also emerged at the negative ends of the scales. Thus, more mothers in the DU than in the control sample showed lack of protectiveness, indulgence, and control. This suggests that while 'over-mothering' has been the lot of many boys who subsequently develop duodenal ulcer, in some cases 'under-mothering' may also be a significant factor.

Colleagues have asked me: What of the boys in the DU sample, whose mothers were neither very dominant, nor displayed the attitudes of protectiveness, indulgence, or restrictiveness? If these maternal attitudes are thought to contribute to the development of ulcer, how are these exceptions explained? Conversely they have asked: What happened to the young men in the control sample whose mothers were dominant and displayed protective, indulgent, or restrictive attitudes to their children?

There were nine families in the DU sample in which the mother was rated positively on one only of the four variables (protectiveness, indulgence, restrictiveness, and dominance), or negatively on one only of the first three of them. In five of the families a parent, and in two more a grandparent, had a peptic ulcer. In the eighth, the father suffered from chronic indigestion but refused to be medically examined. It seemed at least possible that in these cases constitutional predisposition was a more decisive factor than relationships within the family.

In the remaining family the mother was dead at the time of the investigation and, although both father and son gave a great deal of information, this may have been coloured by love and respect for the dead. This mother, who suffered from tuberculosis, appeared to have been a dominant woman, whose controlling and conscientious attitudes were described in the discussion on

¹ The findings resemble those of Ruesch *et al.* (1948), whose 'dominant' and 'idealized' mother has much in common with the attributes of the majority of our DU mothers.

dominance in Chapter IV (page 74). She followed the instructions of her doctor meticulously, which meant that she would not allow herself to kiss her son or to let him come too near to her, and she adhered to a rigid schedule of rest when she was at home. Though both father and son insisted that she was an ordinary loving mother, who was not restrictive of the child's activities, it is hard to believe that the frequent separation from her, and the enforced barrier when she was at home, did not create considerable problems for her son. There was also a certain reversal of parental roles, the father taking over the care of the boy, in the most 'maternal', loving, and conscientious way. He devoted all his spare time to his care, and to visiting or helping his wife.

Turning now to the control families, there were nine in which the mothers were rated positively or negatively for at least two of the four variables. Six of the sons showed marked psychological difficulties in their development, ranging from extreme shyness and nervousness to rebellious and antisocial behaviour. In the other three cases such disturbances were not apparent. Simon Bailey (c 4), the illegitimate child whose mother was described as lacking in protectiveness and indulgence and one who disliked children and could not be bothered with ordinary routine, survived his loveless childhood without any major overt disturbance, being a well-behaved, reserved child with a satisfactory school record. At the time of the inquiry he was well established as a skilled worker and he had as little contact as possible with his parental home. Arthur Bradshaw (c 7) was the only child of a mother mentioned as an extremely dominant woman who was the man about the house doing everything from budgeting to plastering, and of a very ineffectual father. His childhood was reported to have been uneventful. He had plenty of friends, became an effective worker, but though approaching 25 he had never found a close relationship with any girl. His relationship with his mother, though close, was very different from Peter's or Michael's. She had never been particularly ambitious for him nor had she pried into his affairs. They had many interests in common and enjoyed each other's company, discussing technicalities of his work and visiting the Festival of Britain together. The secret resentment or 'passive resistance' so characteristic of Michael and Peter was not discernible in this boy.

The third apparent exception was Don Briggs (C 12) whose family will be discussed in greater detail in Chapter VII. As the father was a chronic invalid, the mother had taken over the role of breadwinner, and was working her fingers to the bone. During his early childhood she had been very protective and possessive towards Don. This boy was brilliant in many ways, winning a scholarship to a grammar school at the age of 11, though he did not take this up. Despite his lack of secondary education, he did very well in the Air Force as a National Serviceman and was rapidly promoted. However, he did not follow up the opportunities which his promotion in the Services opened up for him, and chose to return to a repetitive job in the same factory as his mother, where he worked for twelve or fourteen hours a day in the same compulsive manner as she did. Although he did not show overt symptoms of neurotic disturbance his identification with his mother's ideals was so intense and his compulsiveness so marked that the research team considered recommending him for psychiatric help.

Having examined the exceptions, it still seems true that dominance and attributes of possessiveness on the part of the mothers are associated with the appearance of psychosomatic disorders or neurotic disturbances among the sons. It might well be that the three men just discussed who had established an adequate social adjustment and showed no overt signs of anxiety or rebellion, despite the strains and difficulties in their family situations, may develop a psychosomatic illness such as duodenal ulcer later on in life.

CHILD-CARE PRACTICES

The question now arises whether the differences in maternal attitudes were also reflected in the actual child-care practices of these mothers. Generally speaking, they were not. Although the mothers differed greatly in *how* they approached the upbringing of their children, there was little if any difference in *what* they actually did, suggesting perhaps that practices are in large part culturally determined.

Feeding

All the mothers in the detailed case studies breast-fed their children

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for a considerable time and reported that their babies had been contented at the breast. Mrs Brown and Mrs Cohen described 'slow feeding' when their babies were put on solids and interestingly enough these two continued 'go-slow strikes' against their mothers in later life. All three boys enjoyed their mothers' food in adult life and managed to find jobs sufficiently near home to come back to midday dinner. Two of the mothers, Mrs Brown and Mrs Cohen, stressed that they kept to a rigid feeding schedule. However, similar histories of breast feeding were reported by only some of the mothers in the DU sample and the differences between the two samples were not striking.

Table 12

BREAST FEEDING

	Under 1 month	1-3 months	3-6 months	6-9 months	over 6 months	Total
DUs	5	5	9	11	2	32
Controls	9	6	4	9	4	32

There is a slight suggestion that breast-feeding stopped earlier in the control sample, in that fifteen of the babies were breast-fed for three months or less as compared with ten in the DU sample. If the cut is made at six months, the difference disappears. The majority of mothers in both samples reported that on the whole their babies were happy, healthy, and contented during infancy. Caution seems indicated in accepting these reports at their face value as it is likely that mothers tend to remember the good side of early infancy. There were, however, seven mothers in the DU sample who recalled difficult early feeding experiences, much crying, and restlessness. The common features in these cases appear to be the following: six of the seven mothers lacked the warm protective 'fussiness' that was so common among the DU mothers, nor were they restrictive in their attitudes. Four of these, Mrs Gilbert (DU 3), Mrs Davies (DU 9), Mrs Cross (DU 7), and Mrs Clayton (DU 8) were described in the discussion on lack of protectiveness (p. 90). Distance, rather than closeness, characterized the mother-son relationship, for all seven showed rejecting attitudes towards, or a certain emotional aloofness from, their children, who harboured a great deal of hostility towards their mothers. Six of the mothers also experienced difficult relationships with their husbands. It is perhaps significant that the three

delinquents in the DU sample were found among these seven families, and that five of the children experienced prolonged separation from their mother—three in early childhood and two later.

The six instances of difficult feeding, crying, and restlessness during infancy reported by the mothers in the control sample were more varied. Three of them resembled the experiences associated with feeding difficulties in the DU sample, in that they showed evidence of rejection and a subsequently disturbed mother-son relationship, though the marital relationship appears to have been disturbed in one case only. In the other three cases there was no evidence of this kind of rejection or distance in the mother-child relationship.

These histories of feeding difficulties seem to reveal something of importance about the mothers rather than about the children. The point at issue here is not whether the feeding difficulties actually occurred in these seven cases in the DU sample, or whether the feeding histories of the rest of the sample were in fact as undisturbed as the mothers described them. Rather these stories are taken as *significant projections* of the mothers' feelings about their babies and are interpreted as such. It is possible that the dominant and possessively maternal DU mother has, on the whole, enjoyed most fully the dependent stage of her DU son's life. A typical comment was: 'They are all yours then, a lovely feeling'. She may therefore tend to remember the suckling stage as a good and satisfactory experience, whether this was so or not. It follows that the less maternal and protective kind of mother, who would not enjoy the stage of dependency so much, would remember feeding difficulties and excessive crying more vividly and might have induced or exaggerated these difficulties because of her own attitudes. Since the mothers in the control sample presented a far wider range of personalities there was no reason to anticipate the same division into the more protective, dominant kind who may idealize the experiences of early infancy and the rejecting kind who remember difficult feeding experiences. Instead, all kinds of attitudes might be expected, corresponding perhaps more closely to the actual hazards of the feeding situation.

There were other suggestive differences in the feeding histories of the two groups. Seven of the DU babies were described as

'greedy' feeders as against two in the control sample. Mothers used such expressions as 'a hog', 'a wee glutton', 'he would eat me if he could', 'he has always been a hungry boy', 'he would not leave the breast'. This early appearance of strong oral needs which demand immediate gratification may be of some significance in the pathology of duodenal ulcer. It is reminiscent of Mirsky's hypothesis that those who later develop a duodenal ulcer may be born with hypersecreting stomachs, which would make them orally very demanding, however good a 'feeder' the mother may be.

Another suggestive difference was that ten boys in the DU sample as against five in the control sample, were described as 'finicky' and 'faddy' during their childhood. In most cases the mothers appear to have dealt with this indulgently, often explaining that they avoided clashes by providing the preferred food. This tendency of the mothers to be indulgent over food, to be good 'oral' mothers, who cooked well and served food nicely, was confirmed by many comments of the DU patients themselves.

Toilet Training

The preponderance of obsessional tendencies in the mothers of the DU children would lead to the expectation that greater stress was laid on toilet training in the DU sample than in the control sample. Moreover, all three mothers in the detailed case studies carried out conscientious toilet training from birth.

Table 13

TOILET TRAINING

	From Birth	Early Before 3 months	Later	Not known	Total
DUs	12	11	6	3	32
Controls	18	6	8	0	32

The table, however, shows that if anything more mothers in the control sample started training from birth, and the high incidence of early training in both samples (DU 23, control 22), suggests that this was the prevailing practice at the time. This suggestion seems in line with Gorer's findings: 69 per cent of the mothers in his sample considered training should start before the child is 6

months old, and very early training was particularly favoured by mothers between 35 and 64 (Görrer, 1955, p. 165).

There is some slight indication from the mothers' descriptions, comments, and attitudes that those in the DU sample were more likely to make 'heavy weather' of the training and were more persistent in their efforts. As to the baby's reaction to the training, the majority of mothers in both samples indicated that they had had no difficulties in training their children to be clean. Only five mothers in the control sample and four in the DU sample reported any kind of difficult or rebellious behaviour over the pot or any relapses after control had been established. It requires very little experience of child care to realize that this description cannot always correspond with reality, and it seems likely that most mothers prefer to remember their babies as clean and compliant, while 'the battles over the pot' have sunk into oblivion.

Maternal Attitudes to Sexual Development

Most mothers in both the DU and the control sample denied the existence of infantile sexuality, and very few believed that their sons had masturbated. The majority of mothers in both samples found it difficult, if not impossible, to tell their children about 'the facts of life' although most of them did not regard sex as a tabooed subject. Indeed many mothers in both samples discussed their attitudes to sex freely once they had established a trusting relationship with the P.S.W.

It is difficult to summarize the maternal attitudes and practices which for purposes of presentation have been oversimplified and grouped together under artificially tight and separate headings. In reality they present subtle and unending varieties. The attitudes described are but slight exaggerations of what is common, regarded as a 'good mother': the mother who gives her child loving care and brings him up conscientiously; the mother who protects her child against the cold winds of the outside world; the mother who often cannot do enough for her child, and at times appears to equate giving things in profusion with loving well; the mother whose conscience and ambition, and high standards for herself, urge her to bring out these qualities in her child. This pressure creates difficulties in the personality development of the DU child,

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as will be seen later, but it also encourages the growth of certain strengths in the young man which equip him well for existence in our present society. The qualities that have been observed in the majority of these women are valued highly in our society, and indeed these mothers are, on the whole, intelligent and pleasant women, good citizens and in many ways 'the salt of the earth'. But many of them suffer from neurotic and psychosomatic disturbances, which may be part of the price they pay to achieve these exacting standards, and they lack the warm, natural, easy-goingness and the elasticity that seem such essential features of the climate in which mental health flourishes best.

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CHAPTER VI

The Fathers

As this study of the family background of duodenal ulcer was designed originally with a strong emphasis on the mother-child relationship, and as the mothers were as a rule more easily accessible, the fathers were seen less frequently—usually no more than twice. The fathers in the control sample were on the whole seen more often because a greater proportion of their wives were out at work during the day and consequently many visits had to be paid in the evenings. Moreover, in the DU sample, some fathers felt that after prolonged contact with the mother and the son, the investigators 'knew all about us' and they considered the interviews superfluous. In addition, some of the forceful mothers who had established quite a strong relationship with the P.S.W. and who had often criticized the father quite severely, did not encourage contact between the father and the P.S.W. However, in spite of these difficulties, a good deal of information was gathered, not only from the interviews with the fathers, but also from the mothers' and the sons' comments.

The pilot study pointed to certain recurring patterns in the DU fathers' work situations, in their personalities, and in their relationships to their sons. These themes can be summarized as follows:

1. *The Fathers' Work*

The fathers have very steady work records and tend to stay in one job for a very long time. They are 'plodders' who frequently achieve some promotion but do not like assuming executive responsibility, and do not strive towards it.

2. *The Fathers' Personalities*

(a) *Dyspepsia and Mental Health.* The fathers in the DU sample have more duodenal ulcer and chronic dyspepsia than the fathers

in the control sample. The majority appear to be stable individuals and to have fewer neurotic traits than their wives. If they show disturbance, it is in the direction of anxiety and depression. In these respects they do not differ from the fathers in the control sample.

(b) *Passivity.* The fathers are frequently unassertive, placid and unadventurous men who like a quiet life. The majority seem satisfied with their fate in life and do not strive towards particular goals.

3. *The Fathers' Relationships with their Sons*

- (a) The fathers show a greater tendency to be interested in their children as babies than the fathers in the control sample.
- (b) The fathers show less interest and share fewer activities with their DU sons in adolescence than the control fathers.
- (c) This rather distant relationship between DU son and father results in a lack of positive identification with the father in the DU sample, in contrast to the control sample.

A combination of most of these attitudes was observed in Mr Allen, Mr Brown, and Mr Cohen. Are they also discernible in the sample as a whole?

OCCUPATION AND STATUS

The table shows a considerable degree of steadiness in the employment situation of the fathers in the DU sample. The relative settledness of over one-third of the control sample (13) is also interesting to note. These findings suggest that security of employment is an important consideration in both samples and one which may still be affected by the memory of the depression. It is possible that in the DU sample this striving for security is intensified by the personality characteristics of the fathers, i.e. their cautious conscientiousness, and their dislike of leadership and adventure which will be discussed later.

Table 14

FATHERS' STEADINESS AT WORK

	DU	Control
Marked steadiness (same firm or service for 15 years or more)	20	13
Some changes in employment	8	12
Frequent changes in employment	2	6
Unknown	2	1
Total	32	32

At the other end of the scale there are also some interesting differences between the two samples. Two fathers in the DU sample as against six in the control sample changed their jobs very frequently. One of the fathers in the DU group was very ambitious, still attending evening classes and aiming at higher qualifications when in his forties. His changes were partly due to his ambitious strivings, for whenever he felt that he was not making full use of his capabilities he moved on to another job that would make more demands on him. The other father was seriously unstable, and this led to him being dismissed from many jobs, but he too was a man of considerable ability who had recently changed to a type of employment quite different from his previous calling, and he was very successful in his new job.

Those in the control sample who changed their jobs frequently seemed to be rather different types. They were either drifters or adventurous and almost over-confident. One father lost many jobs on account of his unstable behaviour and his unwillingness to work hard. Another was rather work-shy after a good deal of minor illness. The third was an unskilled man in the building trade who had difficulty in maintaining employment of a seasonal character and was inclined to drift. The other three were of the confident adventurous type. One was interested only in working up a job to a point at which it became a great success and ran smoothly, when he would have an urge to start from scratch in another job. Two were highly skilled steel workers who could command big wages and who suited their own convenience. Thus in the control sample there were no fathers who changed their jobs frequently from ambitious motives. Nor did the three unstable or drifting fathers resemble the father in the DU sample who, though too

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unstable for one calling, made a success of a responsible job in another sphere and did not drift into unskilled employment.

Although so many fathers in the DU sample stayed with one firm or service for long periods at a time, this does not mean that they were completely unadventurous or without desire and ability to get on. Eight of the twenty gained promotion within their firm, as did five of the thirteen controls. The promotions were to chargehand in two instances, in four cases to foremen and supervisors, in one case to works manager, and in another to a higher grade in the Civil Service. In the control sample two men became partners in small businesses, one advanced from bus conductor to inspector, another gained promotion from transport driver to costing clerk in the same firm, and one became a foreman. There are other indications that the fathers in the DU sample have initiative despite their drive towards security at all costs. For example, five of the young DU patients were born in other parts of Great Britain or abroad, and their fathers had moved into the area in search of better opportunities. No corresponding example could be found in the control sample. This pointer may, however, be of little significance, since the DU sample was drawn from a wider area than the control sample, the latter residing exclusively in an old part of a single borough where there has been comparatively little migration. Firmer ground is reached in comparing the number of fathers in either sample who have risen in status during the whole of their work careers.

Table 15 FATHERS' RISE IN STATUS DURING WORK CAREER

	DU	Control
Rise	14	10
Stable	14	18
Decline	2	3
Not known	2	1
	—	—
Total	32	32

Although these differences are very small, there is a slight suggestion that the fathers in the DU sample have got on a little better than the fathers in the control sample. As indicated, in most

cases their rise was modest and in several instances (of which two examples were seen in Mr Brown and Mr Cohen) the fathers refused, or did not exert themselves to obtain, executive posts. On the other hand four fathers in the DU sample as against one in the control sample showed marked ambitious strivings. One who changed his jobs frequently to better himself, and who was aiming at higher technical qualifications, has already been discussed. The second had risen to be a foreman and was endeavouring to become an inspector, and to this end he was prepared to move anywhere. The third prided himself on owning two shops when he was in his early twenties and considered himself very ambitious, and a fourth had risen to be a manager early in life. It may not be without significance that two of these ambitious fathers had or had had duodenal ulcer and that a third suffered from chronic dyspepsia.

In the control sample one father, who started without any skills after World War I, studied liard and gained steady promotion until eventually he started a business of his own.

Thus there were several hints that the fathers in the DU sample were somewhat more ambitious and had achieved a slightly higher status than those in the control sample. On the other hand there is a suggestion that in the control sample there were men more capable of taking risks and assuming responsibilities. Five fathers compared with two in the DU sample had small businesses of their own.

The fathers' work situations may be summarized as follows:

1. There was a general tendency towards steadiness and settledness in both samples, but this was more marked in the DU sample.

2. There was a slightly greater tendency to rise and get better positions among the fathers in the DU sample than among the fathers in the control sample, though this was subordinated to their overriding concern with security and their avoidance of the burden of executive responsibility.

3. There appeared to be some indications that the fathers in the control sample were more able to take risks. More were owners of small businesses.

It is clear that these tentative suggestions, which are derived from small differences in two small samples, need to be confirmed in much larger samples before they can be taken as reliably established.

THE PERSONALITIES OF THE FATHERS

The initial sketches of the three families indicated that the fathers were somewhat unassertive men who left decisions to their wives and whose motto might be: 'anything for a quiet life'. In general the fathers in the DU sample were home-loving men often described by their wives as less sociable and enterprising than they really were. It must be remembered that what the wife saw and reported was coloured by her own needs and wishes and did not necessarily reflect the real situation. Thus some wives indicated that their husbands 'would not open their mouths' if interviewed, but these husbands turned out to be forthcoming and interesting informants. However, their work records, which testify to their quiet stability and their refusal to aim for the top, seem to reflect their unassertiveness and their dislike of, or problems about, assuming authority. The latter is very prominent in their relationships with their sons which, as will be seen later, in most cases were characterized by a non-authoritarian attitude.

Passivity

How did the fathers behave at home? Were they as unassertive as their wives saw them? It needs to be stressed again that in most cases the picture of the fathers was not built up from repeated and prolonged interviews (as it was in the case of the mothers), but from information supplied only in part by the fathers themselves and partly by the mothers and the sons. In some instances little knowledge could be gained about their childhood backgrounds and the details of their life histories. Nevertheless the research team was in touch with the families in both samples for a year or more, and many opportunities presented themselves for observing the father's behaviour and attitudes both directly and indirectly. Even so, the possibility cannot be dismissed that in some instances the father may have been seen through the mother's eyes. This was especially so where the fathers were dead (3 DU and 4 control families) or inaccessible (3 DU families and 1 control family). Since the fathers' personalities were not studied in the same detail as the personalities of the mothers, definite ratings of their behaviour have not been made. For this reason no tables will be

presented in this section, but some indication of the distribution of the attitudes discussed will be given, together with illustrative cases.

Looking at the fathers' behaviour and attitudes in the home, the majority of fathers in both groups appeared reasonably intelligent, constructive, and responsible men with diverse interests and hobbies, who spent a great deal of their spare time improving their homes and tending their gardens. They helped their wives in varying ways, with shopping, washing up, or making the early-morning cup of tea. In each sample there were only three fathers who were neglectful and failed to play their part, by not bothering to paint the kitchen or do any repairs, or by going off on selfish pleasures, and letting the rest of the family struggle along as best they could.

When the attitudes the fathers displayed at home were studied more closely it appeared that more than half the fathers in the DU sample showed certain passive characteristics that seemed to be the counterparts of the mothers' dominance. This passivity was observed in different spheres. For example, in a few cases it consisted in a kind of withdrawal or in contracting-out of certain responsibilities, leaving the mother a clear field, and was accompanied by the father engaging in an interest or a hobby quite separate from the mother's activities.

Mr Fry (DU 16) left all domestic decisions to his wife who was a very over-protective and anxious mother (see p. 87). He was a self-centred, excessively worried and conscientious man who had been attending Out-Patient Departments regularly for many minor complaints and who had worked for the same firm for 30 years. He was not very bright, depended on his wife for everything, and liked to be waited on. He had never given any advice or guidance to his son regarding employment when he left school and had no views on the young man's career. He liked to keep out of the rather frequent squabbles between the patient and his mother or sister. He spent all his spare time on his allotment into which he put an excessive amount of energy, growing vegetables and flowers in such profusion that his family did not know what to do with all the produce.

Mr Cameron (P U 6) was much quieter in his ways than his wife, whom he called 'a chatterbox who has to spit everything out'. He took a passive attitude towards things and often used the expression 'there is nothing you can do about it'. His wife was the ambitious leader of the household and her move to the South from Scotland and her determination to get on has already been described (see p. 67). Mr Cameron remained essentially a countryman of simple tastes and few words who would not discuss his wife's schemes, her gossip, or her worries about their son. He would never be drawn into an argument but wrapped himself in silence, or withdrew into the garden. He considered the garden his main hobby just as he described the mother's hobby as 'housework and changing the furniture about'. Another sphere in which the father found an outlet away from his wife was playing whist, which he did regularly two evenings a week. Another interesting indication of the separation of spheres of interest was that the father continued to visit his hometown in Scotland for holidays while the mother travelled abroad to visit her ex-employers.

Mr Austin (D U 2) made a pact with his wife, when his only son was a toddler, that she would take over his discipline and he would keep out of it. When the child was evacuated and extremely unhappy, the mother turned to the father for advice. The father refused to give it, saying, 'You decided to send him away, you will have to decide about bringing him back.' He, too, spent many hours on his technical hobbies in his workshop.

Mr Fletcher (P U 21), the husband of an extremely managing and efficient business woman, also responded by accepting his wife's dominance in the home and by spending four evenings a week helping a friend in his café.

In the control sample there were also some fathers who left all major decisions to their wives, but only two of them created separate spheres of interest for themselves, both of them being fishing enthusiasts. The others appeared to adjust themselves wholeheartedly to their wives' needs. For example:

Mr Gates (C 15) was a man who had stayed in the same job for 20 years. He had received severe injuries in World War I that

often caused him much pain, but he would never draw attention to himself. In the interviews with the P.S.W. he had very little to say and he was completely overshadowed by his wife. He revealed without apparent embarrassment or resentment that he had learned to mend his own socks and clothes as his wife did not like sewing.

Another way in which passivity showed itself was in the kind of functions the fathers performed in the home. There were five fathers in the DU sample who waited on their wives, or performed what might be regarded as feminine functions in the home. For example:

Mr Franklin (DU 4) was a friendly, forthcoming man who made no bones about the fact that he was well satisfied to be retired at the age of 67 although he still seemed very fit and vigorous, and the family had very little money. He enjoyed his leisure and used to wait on his wife who went out to work, getting her breakfast in the mornings and her cocoa in the evenings. He recognized the mother's leadership and drive with placid acceptance, saying, 'There isn't room for two like her.'

Only one such case was encountered in the control sample; Mr Hodges (C 2), who will be discussed in greater detail in the next chapter.

Yet another hint that some of the fathers were followers rather than initiators was to be found in their admiration for, and occasionally their emulation of, their more adventurous sons. Mr Castle (DU 24) had been a driver for 25 years. At the age of 50 he took up his son's career as a cashier with a chain store. Another father copied his son's hobbies, and a third said quite openly when his son left home in order to get better training experience, 'I would never have had the initiative to do this.'

In the absence of any intensive clinical studies of the fathers, it is not possible to say how much their passivity springs from a somewhat immature need for dependence, how much it may be a mature and conscious adjustment to their effective and dominating wives, or how much it is due to social changes related to the democratization of the family and to the censorship of overtly aggressive and authoritarian behaviour. It is very likely that all

these three factors are at work and interact. Mr Glover (C 18), a father in the control group who appeared to exercise democratic leadership in his family, summarized the cultural changes thus: 'My father, who was a heavy drinker, used to come home from work in the evenings, change, and go out with his companions without even consulting my mother. I hardly ever go out without consulting my wife, but at a push I would go without explaining, and consider it my right. My sons would never dream of going out without asking their wives first. This is the emancipation of women for you.' There is little doubt that in the control sample more fathers took the initiative in the home, shared decisions with their wives, and were not afraid of having an argument or putting their foot down. Nor were their hobbies so clearly designed as separate activities. However, it is worth noting that there were only three cases in which the wife actively joined in her husband's hobby. Mr and Mrs Austin (DU 2) met at a rambling club, and hiking has remained their preferred joint hobby. Mr and Mrs Cohen (DU 11) shared activities in Jewish community affairs, and Mrs Baker (C 1) had taken up angling with her husband. For the rest, there was no indication that the mother shared or felt she should share in her husband's interests or hobbies, which were regarded as belonging to a separate 'male' world, rather like his work. This seems to be in accordance with customs in homogeneous working-class areas described in other family studies (Robb, 1954, p. 61; Dott, personal communication, see also 1955, 1957; Young and Willmott, 1957), where the men have some independent companionship outside the home (dart club, pubs, etc.) and the women cultivate the visiting of relatives, more especially their own mothers and sisters. The notion that husband and wife should share activities and interests seems mainly a middle-class one, and may be related to life in a heterogeneous neighbourhood where friends and relatives are scattered, so that husband and wife are more dependent on each other for their psychological and social satisfactions.

In both samples there was a minority of fathers (6) who clearly assumed leadership and major responsibility at home. In the DU sample such fathers stood out because of their ambition and general drive, a characteristic already mentioned in the discussion on maternal dominance.

Mr Fuller (DU17) was a restless man who knew what he wanted and was determined to get it. He took all major decisions in the home and still expected immediate obedience and deference from his grown-up sons. He was dogmatic and never changed his opinions.

Mr Anderson (DU27) was a man of very high intelligence with a responsible job, who was ambitious and took it for granted that the household should revolve round his needs. He would not allow his wife to go out to work although their only son had left home. He urged his son to continue with further education and was very disappointed when he gave this up in order to pursue his courtship. He was somewhat contemptuous of his son's dependence on his mother in childhood and of his inability to stand up to other children. This man grew up in a different country where it was taken for granted that women should wait on men, even to the extent of cleaning their shoes.

Mr Casey (DU29) was a man of initiative with a good opinion of himself. He compared his son's lack of initiative unfavourably with his own sense of adventure in youth. He, too, sounded a note of contempt, for example, about his son's acquiescence in living with his parents while his young wife lived with her parents. He said, 'If I had had to live in a cupboard I would have insisted on being with my wife.' He stressed that he was the 'governor' in the home and at one stage when his son would not cooperate with the family he ordered him out of the house. After the son had spent several months in lodgings, the father had a talk with the boy, and pointed out that there was only room for 'one governor' in the house. The son returned on this understanding.

It may be significant that two of the fathers just mentioned had duodenal ulcers and the third suffered from chronic dyspepsia. As will be shown later in the discussion of their mental health, a considerable need for dependence appeared to underlie their marked assertiveness.

In the control sample there were examples of different types of leadership ranging from the aggressive type of 'beef, brawn, and

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beer' to the balanced democratic kind of leadership exemplified by Mr Glover (C18).

In over half the DU families the picture that emerges of the fathers' attitudes at home did partly confirm the mothers' descriptions of passive acceptance of their leadership. But there have been some hints that in their own quiet way these men create niches for themselves and their creative abilities well away from their wives' sphere of control. Thus they appeared in some respects as somewhat passive, in others as constructive and versatile, but almost always as unassertive and quiet in their general manner.

DYSPEPSIA AND MENTAL HEALTH

Taking into account their steadiness on the one hand, and their apparent control of aggressive impulses on the other, it was not surprising to find that these fathers had a great deal of psychosomatic illness and little overt neurosis.

Table 16 DUODENAL ULCER AND CHRONIC DYSPEPSIA
OF THE FATHERS

	DU	Control
Duodenal ulcer	8	5
Chronic dyspepsia, nature undiagnosed	4	0
	—	—
All cases of chronic 'stomach' disorder	12	5
No evidence of du or chronic dyspepsia	20	27
	—	—
Total	32	32

Duodenal ulcer and chronic dyspepsia. Table 16 shows a preponderance of stomach disorders in the DU sample. The four fathers suffering from chronic dyspepsia were sufficiently ill to have attended out-patient departments and to have been X-rayed. The fathers with duodenal ulcer had certain characteristics in common. Five of the eight with duodenal ulcer had invested a great deal of energy in their work and had striven more than most men in the sample. There were suggestive indications in their life histories of the struggle between dependent needs and independent strivings which is so often quoted as characteristic of the basic conflict in the psychopathology of duodenal ulcer (Alexander, 1952, p. 102.)

Mr Henderson (DU 5) was the son of an extremely possessive and dominating mother who always gave him a feeling of wanting to 'smother' him. He strove to become independent of her in childhood by avoiding being kissed and fondled, and he left home early. He married a woman who was as dainty and feminine as his mother had been big and dominating. This move could be interpreted as a striving towards independence. However, his dependent side led him into domestic service where he put up for years with a very imperious female employer. She submitted him to many humiliations, although at the same time she was very fond of him and also kind to him. He developed his ulcer at a time when he was under particular stress from this employer and unable to get home to his family every night. He managed to break away from this stage of dependency. He opened a shop of his own in 1938 in which he was very successful, until the war forced him to shut it. He was called up into the Army and rose to the rank of sergeant. He enjoyed his Service life and his symptoms disappeared. On his return to civil life he again set up a business of his own, but this failed. His symptoms returned. He had a severe haematemesis and became increasingly more dependent on his wife. In response to his needs she took on a leading rôle, making important decisions about acquiring property and budgeting their finances.

Mr Anderson (DU 27), already discussed as a leader in his home, was a highly responsible works manager with an overdeveloped conscience, who found it difficult to take a holiday and who had great ambitions for his son. He made all the decisions in the home and the household revolved round his needs. His dependent needs were as a rule well concealed and he kept control over his feelings. His doctor once pointed out that he 'swallowed his feelings'. One indication of the conflict between his dependent wishes and his striving for independence was his refusal to be treated for a physical disability. Instead he relied for help on his wife who had to accompany him wherever he went.

Mr Cross (DU 7) was very successful in his work. He married a very shy mother-bound young girl whom he tried to dominate

completely, to the point of physical cruelty. He was inordinately jealous of her. There were also signs that he needed to depend on her like a child on its mother. For instance, he insisted that she should wave to him every morning as he was leaving home. He was very jealous when a baby was born and could not bear to see his wife feeding it. His wife, on the other hand, was unable to give him either sexual or maternal love, as she was frigid and deeply tied to her mother. After she had left him he married a much older woman who had been looking after him for a long time while he was in lodgings, and at the same time continued to pursue his first wife.

In the control sample the fathers with duodenal ulcer also provided interesting illustrations of dependent needs and struggles towards independence. Two of them became confirmed invalids with much additional illness, their dependent needs gaining supremacy. They made heavy demands on their wives, who responded with masochistic eagerness (Mr Bradshaw (C7), Mr Briggs (C12), p. 141, 150). A third, Mr Barlett (C10), though very ill with a cardiac complaint and bronchitis, struggled to work every day to the amazement of his general practitioner. In the evening, his family, and in particular his unmarried daughter, waited on him while he dozed in front of the fire. The fourth, Mr Barry (C19), was markedly unassertive, and put up with a good deal of domestic discomfort and criticism from his wife. His conflict between his dependent and independent needs became overt at work. He had reached the grade of inspector, but the exercise of authority posed a difficult problem to him. He talked at length about his attempts to be 'fair', and about the great care he took to remain on equal terms with the men. His dilemma seemed clear. His independent and ambitious drive was pushing him towards the top. His dependent needs and his desire to be loved led him to attempt to deny the authority of his role and to identify with his subordinates.

Neurotic traits. Six fathers in the DU sample and five in the control sample displayed neurotic traits. Thus the amount of neurotic disturbances appeared to be less among the fathers than among the mothers, although the limitations of the investigation preclude

certainty on this point. However, this does correspond with other epidemiological pointers and clinical impressions that females are more prone towards neurotic disturbances than males (Fraser, 1947, p. 4; Freud, 1948, p. 117; Gorer, 1955, p. 282; Registrar General, 1949). A common trend can be detected in the men's symptoms in the direction of depression, anxiety, and hypochondriasis.

Mr Fry (DU16) had been attending hospitals for many years for all kinds of minor ailments, among them stomach complaints considered to be gastric neurosis. He talked at length and animatedly about his hospital experiences, which were an important part of his life, and proudly displayed his many medicines.

Mr Gilbert (DU3) was described by his wife as a 'bundle of nerves'. He was an anxious, worrying type of man who never left his fireside in the evening and who occasionally suffered blackouts at work when he was carried home on a stretcher. However, at the conscious level, he was a most conscientious worker who usually arrived at work an hour early. He has been mentioned before as an unassertive father carrying out feminine functions in the home.

Mr Armstrong (DU23), a father who also exhibited passive traits, was a permanent invalid who after long and conscientious service to his firm was pensioned off with chronic bronchitis. He too seemed preoccupied with himself and his illness and he was settling down to being looked after by his strong, energetic wife, who was fast becoming the man about the house. He jokingly referred to the reversal of roles, saying that she went to work and kept them going while he looked after the house.

Mr Foster (DU22), was an anxious, rather limited man with depressive tendencies, ineffective and inactive in the home, who had had what he called a nervous breakdown some time ago. He had been carried completely by a very active competent wife and, when seen as a widower, conveyed a rather pathetic picture of isolation, being bossed around by his eldest daughter.

Mr Harris (DUI3) showed very different symptoms. From the accounts of his wife and children he seemed a grossly paranoid and exceedingly promiscuous man, whose interpersonal relationships were very disturbed and whose severe temperamental instability had lost him many jobs.

In the control sample some fathers also displayed pronounced hypochondriacal and depressive symptoms.

Mr Blake (C3) was much concerned with his bowels and his inside generally and complained of many symptoms which his general practitioner had dismissed rather lightly. He talked at length about his anxieties, but even with help was unable to take any constructive steps regarding treatment, as though he needed his complaints as a protective device against even worse anxiety. He was so preoccupied with himself that he had little energy left for any other interests, and he was often out of work.

Mr Bradshaw (C7), who also had a duodenal ulcer, was called a 'severe neurotic' by his general practitioner. He enjoyed his invalidism, took an attaché case full of assorted medicines to work every day, and loved being waited on by his wife, whose need to have a dependent husband was so strong that she made him still more helpless by her attentions (see p. 141). In spite of his preoccupation with illness he managed to work most of the time as a commissionaire.

Mr Fenton (C20) was another permanently disabled man doing a sheltered job who had been on public assistance for a long time. When medically examined he stated, 'as soon as I got a job, after an hour's work I got so weak that I had to give it up' and the doctor concluded that the diagnosis was neurasthenia.

Mr Dunn (C22) had committed suicide by poison. He appears to have been a very conscientious worker who was excessively accident-prone. The story was that his last severe accident had led to considerable impairment of his mental balance. (This story could not be confirmed because his hospital records were lost.) Immediately prior to his suicide he had mismanaged some money with which he had been entrusted by a friend.

Although Mr Ford (C21) showed serious symptoms at one stage of his life, it is doubtful whether he should be included here. He was a very competent, well-adjusted person who broke down with a reactive depression after the death of his wife whom he had nursed for years under most trying wartime circumstances. During this period he had also lost his eldest son on active service.

It seemed, then, that many of the men's mental health problems centred on dependency, some of them openly becoming dependent children again by a variety of means. This raises interesting questions: will these tendencies be found in larger samples? If so, to what extent are they the result of the stresses involved in the rapid changes in male and female roles that are robbing men more than women of some important emotional supports? (Halliday, 1948, p. 166; Spiegel, 1953). In former generations, while men had to shoulder the struggles of bread-winning, many of them enjoyed the satisfaction of being the unquestioned head of the home on the one hand, and of getting maternal comforts from their wives on the other. They also often enjoyed the support and help of other male members in the extended family. Gradually these satisfactions and supports have become much reduced. The breadwinner is solely responsible for maintaining his family and the support he receives from his male kin is very much diminished. Indeed, relatives are often the last people from whom advice and help is sought. Moreover the ever increasing division of labour at work, the increased size of the undertakings, and their impersonality combine to strip work of much of its satisfaction. This contributes to the strains on men in their roles as workers outside the home. Strains are also apparent in the working-lives of men in the middle classes. There is a growing emphasis on formal qualifications and competition for higher posts in the professions and the business world alike, and there are fewer opportunities of establishing a fair-sized business or of working as a professional person on one's own account. At the same time the husband's and father's authority in the home is considerably diminished and with it, possibly, the satisfaction derived from the discharge of aggression and the enjoyment of power. The working out of a more democratic division of authority

within the family demands much more maturity on the part of the individual members, and may produce more stress as well as more satisfaction in the end. Further, wives appear much less prepared to be mothers to their husbands as well as mates. In fact, the seeking of a 'mother substitute' in a wife has become a matter for reproach. In spite of the withdrawal of some of these fundamental emotional supports, men are still expected to be 'manly in their conduct'. They are expected to control their feelings much more than women, and should not cry privately, still less in public. That is to say no allowances appear to be made to balance the loss of opportunities of discharging aggressive and dependent impulses. Thus it would not be surprising if men should seek outlets for their dependent and aggressive needs in the veiled forms of neurosis and particularly of psychosomatic illness (Mittelman and Wolff, 1942).

Excessive drinking. One small, but perhaps suggestive difference between the control sample and DU sample, was the amount of excessive drinking found (control 5, DU 2). Five fathers in the control sample drank heavily at week-ends to the extent that they came in drunk or stayed away altogether, thereby causing serious friction in the family. All of them were steady workers. Although three of the wives made attempts to separate, only one, a woman with very firm views about hard work and respectability, left her husband. The sons of these fathers reacted in quite opposite ways. Two had a positive relationship with their fathers, and were not at all averse to drink themselves. Three criticized their fathers strongly and vividly remembered the suffering they and their mothers endured as a result of their drinking.

The two men in the DU sample, Mr Davies (DU9) and Mr Morgan (DU30), who drank heavily were somewhat atypical of the general run of fathers in that they both took far less interest in their homes. Both had sons who became seriously delinquent in adolescence. It is perhaps a comment on the atmosphere of respectability prevalent in the DU families that the extent of the fathers' drinking and the disruption this caused in their families were not revealed to the P.S.W. for over two years. In the control group, on the other hand, drinking was acknowledged fairly easily. It was somewhat surprising to find this proportion of heavy

drinkers among the fathers at a time when alcoholism is no longer considered to be a 'social problem' in this country. It is true that these fathers could not be described as confirmed alcoholics. They were meeting their economic obligations and were fairly steady workers, but the amount of unhappiness and disruption caused in their families was considerable. It may be, of course, that they were still affected by the habits of the previous generation, to whom drinking was a much more serious problem: three of these fathers were known to have had very alcoholic parents.

Although the figures are very small (5 : 2) the contrast between the two samples in regard to the fathers' habits is of psychological interest.¹ It may reflect the greater respectability and conformity of the ulcer families; and may point to the easier gratification of instinctual urges, and to greater assertiveness in claiming the right to do so, in the control sample. Discussing the ulcer problem in modern Western society, a distinguished Dutch physician said in effect, 'The trouble is they are all expected to behave like gentlemen nowadays. Even 50 years ago men used to let themselves go thoroughly on the Queen's birthday; there were drunken brawls galore and if they felt like it they used to beat up their wives.' Halliday also contrasts the 'loose, licentious soldiery' of the Boer War (1899-1902) with the 'relative orderliness, sobriety, subduedness and chastity' of servicemen in the war of 1939-1945 (Halliday, 1946).

FATHER-SON RELATIONSHIPS

In both samples the overall impression conveyed by the material was of the tolerance and the easy-going attitudes that the fathers showed towards their sons, and of the lack of overt conflicts between them. The relationships also seemed less intense than those between mothers and those sons who later developed ulcer. There was a prevailing notion that the fathers were neither stern nor strict, but lenient and friendly on the whole, 'like pals', though the mothers often maintained that their sons took notice 'immediately Father spoke'. The latter observation could not be confirmed by what the P.S.W. actually saw on her visits, and it

¹ It is worth remembering, however, that the greater incidence of ulcer and chronic dyspepsia in the fathers in the DU sample may have restricted their drinking.

seems possible that this notion of the father as the ultimate authority is a stereotype that is still being carried over from the previous generation. Among the phrases used to describe the relationships between fathers and sons were: 'I never believed in being the heavy father', 'We were just pals together', or 'They've done things together like brothers', 'I believe in letting them find things out for themselves'. Some described their attitude towards discipline by saying they would give their sons 'a reasonable telling off but no punishment', and others talked about 'a reasonable amount of freedom'. This easy-going attitude seemed to prevail in almost two-thirds of the families in both samples, the only difference being that the fathers in the DU sample, though tolerant, seemed less involved in their relationships with their sons than the fathers in the control sample. From the boys' point of view, too, the father was in most cases felt as a reasonable figure who was not strict.¹ There were only six fathers in the DU, and three in the control sample who were described as strict, and who were feared in some way or other. In the control sample these fathers beat their boys for disobedience and, incidentally, all of them were rather fond of drink. The strictness in the DU sample was of another kind. In four instances it concerned tidiness, cleanliness, time keeping, and manners, and in the other two it meant the strap for general mischievousness.

There is a suggestion in the material that the fathers in the DU sample showed a greater interest in their children as babies than did the fathers in the control sample. Six fathers played an active part in looking after the baby and showed pronounced interest in their children when they were small, in contrast to their comparative lack of interest and sharing of activities when their sons grew up. This contrast was not reported in the control families. It may be relevant that Robb describes a state of affairs in Bethnal Green that bears a closer resemblance to the behaviour of the DU father. 'Men appear to take a great deal of interest in the smaller children, especially at the toddler stage. In spite of this a father is unlikely to have much close contact especially with the older children. Often he seems to appear as rather a remote figure, by contrast with the mother' (Robb, 1954, p. 50).

¹ cf. Allcorn (1954). He found that most of the young men presented their fathers as friendly, reasonable beings who made no attempt to interfere in their affairs.

One possible interpretation of the fathers' interest in their children as babies is tentatively offered: all six fathers in the DU sample who took this kind of interest showed evidence of marked dependent needs and would have liked their wives to mother them, which for the most part the latter refused to do. It was perhaps easier for these fathers to identify with their sons as infants, a part which they themselves unconsciously, and sometimes consciously, wished to play, or to identify with the mothers (and thereby express a feminine part of themselves) in looking after the baby. As the sons grew up, the conflict within the fathers became more difficult to resolve. The sons, though grown up could still claim and receive the maternal love that the fathers also wanted, but did not get. This may underlie the feelings of jealousy on the part of the fathers indicated in the three detailed case studies. A similar interpretation as to why fathers should be more eager to identify with their sons as toddlers could be advanced for Robb's findings, because he stresses that the toddling stage is emotionally the most satisfying and secure one of childhood life in Bethnal Green.

The most striking feature in the father-son relationship in the DU group was the comparatively small amount of contact between them, the lack of companionship and shared interest, such as football, cricket, and other hobbies, during later childhood and adolescence. In other words father and son seemed to be doing very few things together, and the father's influence was felt very little. In the control sample there was more contact between fathers and sons, and consequently the young men felt differently about their fathers and identified with them to a greater extent. Very few of the DU patients seemed to want to emulate their fathers and be like them, whereas quite a number of the young men in the control sample said in effect, 'I want to be like my Dad.' These differences appear in the table overleaf.

During their early childhood four patients in the DU sample had no father figure. Three of these are the DU boys whose parents separated when they were under two years old, the fourth lost his father at eighteen months, but his mother remarried when he was nine. Only one boy in the control sample had a similar experience when his parents separated during his early childhood. This may be a significant pointer to a hypothesis worth testing on larger numbers: namely to what extent the absence of a father figure in

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DISTANCE IN RELATIONSHIPS OF FATHERS
TO THEIR SONS

Table 17

	<i>DU</i>	<i>Control</i>
Little communication and sharing of interest	18*	9*
Much communication and sharing of interest	9	17
Close relationship	5	5
No father	—	1
	—	—
Total	32	32

* These figures include three boys in the *DU* sample and one in the control sample whose parents were separated during their early childhood.

childhood (ranging from his physical absence to emotional distance) is an important factor in the development of psychosomatic illness, neurosis, and delinquency. Mittelman and Wolff, (1942), for instance, mention the absence of the father as a feature found in the childhood background of some of their ulcer patients. The childhood histories of Stott's 102 delinquents reveal the absence of a father figure in the majority of cases (Stott, 1950).

Eighteen *DU* boys appeared to have a rather distant relationship with their fathers. For instance they did not attend football or cricket matches with them, or their fathers had little to do with their choice of employment. Some of the young men were critical of their father's lack of participation and helpfulness in this latter respect. This tendency to refrain from advising their sons on their choice of jobs in case they 'stood in the childrens' light' has also become apparent in studies of young men in other industrial areas. (Logan and Goldberg, 1953, p. 328; Allcorn, 1954, pp. 92-95; Bevington, 1933, pp. 89-90; Martin, 1954; Mays, 1955, p. 100). This trend virtually represents a reversal of the practices of previous generations when parents often chose their childrens' jobs for them irrespective of what the children themselves thought, a practice that frequently resulted in unhappiness and resentment on the part of the children. One father in the control sample became vividly aware of this problem when discussing his own youth. He had received firm guidance about his career from his father which he had resented at the time, but which had resulted in comparative success. He contrasted this treatment with his own tolerant and somewhat passive attitude to his son's whims and

wishes. As a consequence his boy was tending to drift from job to job and the father now regretted that he had not had the courage to be firm and to give his son definite guidance. This lack of shared leisure interests and activities between fathers and sons may also have its roots in the increasingly common notion that during later childhood and adolescence activities with friends of one's own age are the most important and the most desirable ones, and that it is 'cissy' to go to football matches with one's parents (Mays, 1955, pp. 88-92; Allcorn, 1954, Chs. VIII-IX). Parents, for their part, also advocate increasingly that children must be encouraged to mix with other children of their own age. However, there is little doubt that the fathers in the control sample—in line with their more active temperaments generally—made greater efforts to watch their sons playing football and cricket, or to join in their games, to go out with them, and to take an interest in their other pursuits. Conversely their greater activity on behalf of their sons, and with their sons, invited more admiration and identification on the sons' part, a point that is discussed in more detail in the chapter on childhood.

The findings on the characteristics of the DU fathers can be summarized as follows: just as the main features of the majority of the mothers were their dominance and over-protection, so the main characteristics of the fathers were their unassertiveness and the relatively small part they played in their sons' lives. Their passivity appeared to some extent in their behaviour at work where they avoided taking on too much responsibility and tended to stay in the same job for a very long time. It was also observable at home where they acquiesced in the leadership of their wives. It appeared in the psychopathology of their psychosomatic and neurotic symptoms. Finally their passivity affected their relations with their sons, for, although friendly and easy, these lacked vital presence and positive guidance, particularly in later childhood and adolescence.

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CHAPTER VII

The Marriages of the Parents

So far the main emphasis of the discussion has been on the mothers and fathers as individuals in terms of their background, their mental health, their attitudes to each other and towards their children. In order to understand the family background of our young patients and controls in any dynamic sense, however, we need also to study the most vital relationship at the heart of every family—the marital relationship of the parents. Reference has often been made to these relationships in order to illustrate the ways in which the parents' personalities expressed themselves. In this chapter the nature of the marital relationship itself is the main focus, though the personalities and needs of the parents are regarded as important determinants of the nature and quality of the relationship.

The three initial case studies demonstrated the crucial nature of the marital relationship linking the childhoods of the partners with those of their children. It became clear how the parents' experiences in childhood had affected their choice of partner and the roles that that partner was expected to play, and how the satisfactions and frustrations of the marital relationship influenced the parents' attitudes to their children.

It is generally believed that stable and harmonious marriages in which the partners' needs are fulfilled are likely in turn to produce happy, stable children. Not only do such children grow up in an environment of affection and emotional security, but they are also in less danger of having to compensate a parent for the frustrations experienced in marriage than are children of unsatisfied marriage partners. It is therefore important to explore, in the two samples, the degree of stability of the marriages and the satisfaction found in them. The question arises whether disappointments and frustrations are more frequent in the DU marriage and whether these dissatisfactions in turn press more heavily upon the

children, a phenomenon which was particularly well illustrated in the Brown and Cohen families.

Previous discussions of the parents' personalities suggest that there is a characteristic pattern in the marital relationships of the parents in the DU sample that distinguishes them from those of the control sample. It will be recalled that in the marriages of the Allens, the Browns and the Cohens, a more passive husband had accommodated himself to a striving, rather dominant wife. All the three wives, but particularly Mrs Brown and Mrs Cohen, were disappointed in their husbands in some respects, and were compensating for their disappointments by trying to shape their sons into their image of the 'ideal man'. The outward stability of the relationships and the accent on duty were noticeable, even where tensions were marked as in the Brown family.

Similar notions had emerged from the pilot study, and it seemed worth while to scrutinize the case material for confirmation of these suggestions. At the same time this investigation provided an opportunity for observing at close range a great variety of marital relationships in a small sample of ordinary people. In view of the current general concern about rising divorce rates, women going out to work and declining moral standards, it seemed important to look at these relationships dispassionately and to describe them in their variety and complexity. This section will therefore, contain many examples of how these couples worked out their lives together.

CRITERIA USED IN ASSESSING MARRIAGES

In trying to describe and assess varying degrees of stability and satisfaction in marriage, a number of difficult problems immediately present themselves. What criteria should be used? Is it not presumptuous even to attempt to set up some criteria of what constitutes a 'good marriage'? In any case, since marriage is such a fundamental human relationship capable of satisfying so many different needs, it can hardly be encompassed by a few criteria, however carefully selected they may be. Whatever criteria are established readers will say—and justifiably—'Why these and not others?' The criteria presented below emerged from the experience of these sixty-four relationships and from an attempt to

understand the forces involved. I am conscious of the crudeness and inadequacy of these criteria and only suggest them as a rough guide.

To begin with one basic assumption is made: that the marital relationship is an ever-changing process and not a given state. The potential constructiveness or 'goodness' of a marriage is therefore not judged on the basis of some ideal notion as to what constitutes a happy marriage, but on the basis of whether the specific needs and expectations of two actual partners find some fulfilment in the relationship, which will then act as a binding force drawing them together; or whether their needs are unfulfilled resulting in frustration and an ever greater distance between them. The prime necessity in order to relate oneself to another human being is some form of communication. This need not necessarily be language alone, for communication can be conveyed by gestures, feelings, and the sharing of activities. The degree and ease of communication between the married partners is therefore the first criterion in the assessment of the quality of the marital relationship.

The most potent force striving towards union is of course love; and so evidence of affection is the second criterion. The presence of love as a binding force, however, does not imply complete absence of hostility. It does imply that in the long run positive feelings will outweigh negative ones. These positive feelings can range over a wide field, from the sexual aspects of the relationship to a sharing of ideas and values.

The third criterion is the complementary nature of roles, a concept that again stresses the fluid nature of the relationship. The term role, as used here, does not imply that certain fixed responsibilities or functions necessarily belong to husbands while others *a priori* belong to wives. The point at issue is whether the roles taken up fulfil the partners' basic needs. The 'fit' of a marriage will thus depend on whether the roles played complement each other, however unconventional they may be. In both samples there are striking examples of satisfying marriages in which roles have been ingeniously redistributed or created to suit the needs of both partners. The more the needs and expectations of the spouse coincide with the roles the partner is willing and able to perform and thus with 'reality', the more satisfying the relationship will be

for both. Where the needs of one partner lead him to expect the other to play roles that he or she is unable to fulfil, or that are direct projections of childhood needs, unaltered by the reality of the marriage, stress and frustration are bound to arise.

Fourth, no suggestion is made that absence of tension or difficulty is essential to a successful marriage. Rather, the criterion is the ability and preparedness of the partners to work through difficulties and tensions arising within the relationship.

Lastly, the recognition and positive acceptance of individual differences is proposed as a criterion of a successful marriage.

Since these criteria were established and used in the assessment of the marital relationships in this study, the results of Gorer's survey (Gorer, 1955, p. 138) on various aspects of family life among readers of *The People* have become available. The answers of men and women who were or had been married to the question: 'What do you think goes to make a happy marriage?' provide a valuable check on the extent to which these criteria are realistic or wide of the mark as regards the experiences of ordinary married couples.

The five qualities most frequently mentioned as making for happy marriages were: give and take, understanding, love, equanimity and mutual trust. It seems clear that the first three items are embodied in the criteria of ease of communication, evidence of affection, complementariness of roles and tolerance of differences. Equanimity may be related to the criterion of 'ability and preparedness to work through difficulties' but it seems to lay more stress on the absence of hostility and control of emotion. One wonders whether 'equanimity' constitutes an ideal to be striven for rather than something actually experienced. 'Mutual trust' seems related in some way to the criterion of 'positive acceptance of differences' but it may also be another way of expressing the notion that positive feelings should outweigh negative ones.

It seems, then, that the criteria proposed are not out of keeping with the experiences of a large sample of married people in England. On the basis of these criteria the marriages have been assigned to one of three categories.

1. *Harmonious Marriages*, in which there was evidence of good communication, affection, complementary roles, working

through tensions when they arose, and tolerance of each other's differences.

2. *Outwardly Stable but Precarious Marriages* where much hostility and criticism of the partners were encountered, where roles often clashed and did not meet the needs of the other spouse, where tensions were not worked through, but were at best 'put up with', each partner deciding to go his or her own way, without, however, considering separation.

3. *Broken Marriages* in which friction and incompatibility were so serious that they had led, or were likely to lead, to separation or divorce.

Table 18 MARITAL RELATIONSHIPS OF PARENTS

	DU	Control
Harmonious marriages	16	20
Outwardly stable	10	7
Broken marriages	5	4
Never married	1	1
Total	32	32

Comparing all outwardly stable and unbroken marriages, there is no difference between the DU and the control sample, although more harmonious marriages were found in the control sample.

It is perhaps surprising that half of the DU marriages were rated as harmonious. It might at first sight appear that if the needs of the parents were fulfilled in the marital relationship no major difficulties should have arisen between parents and children and particularly between mothers and sons. Yet, it may be recalled that the Cohens' marriage, which was in most respects a happy and satisfying one, could not fulfil all the mother's needs, so that she sought to satisfy some of them through her son. A similar situation could be detected in other DU families where the marriages were satisfying relationships fulfilling important needs of both partners, possibly at the expense of the children. It seemed that their success was in no small part due to the adaptability and the good humour of the husbands, who made it possible for the wives to control and lead and yet to indulge their dreams of having a strong successful man in the shape of their growing sons. It was not unexpected to find that the number of broken marriages in each

sample was almost the same, since this had never been considered a characteristic feature of the family background of duodenal ulcer. The proportion of marriages in both samples that turned out to be failures, (although not all of them have been dissolved) seems to be in accordance with other estimates (Slater and Woodside, 1951, p. 290). In half the marriages in the DU sample but in only a quarter in the control sample, stability had been achieved through the acceptance by unassertive husbands of their wives' dominance. This proportion is appreciably less than the number of dominant mothers given in Table 8 (p. 72), namely twenty-two. This suggests that although the mother can be the dominant influence and carry the major responsibilities in the home, this dominance is not necessarily carried over completely into the marital relationship. Examples of precarious marriages where the husband resented his wife's dominance or sought satisfaction outside the marriage illustrate this point. The mother's disappointment in the father came out most clearly in the disturbed and outwardly stable marriages. Thus, eight of the ten mothers in this category in the DU sample voiced such disappointment. This is readily understandable because these are the marriages in which criticism and unresolved dissatisfaction were most marked.

The ways in which the marital relationships had been worked out were extremely varied, but once again there was less diversity in the DU sample than in the control sample.

HARMONIOUS MARRIAGES IN THE DU SAMPLE

Mr and Mrs Henderson (DU5) have already been mentioned in previous sections where the father's conflicts over dependence in relation to women were described. Over the years there had been interesting shifts in the needs expressed and the roles assumed within the Hendersons' marriage. It was suggested that the father chose the mother in part at least because she was unlike his possessive, overpowering mother. It seemed that for a number of years the father was the leader in the marriage, the mother being a sensitive, loving, and responsible partner of considerable intelligence. During the war, however, the equilibrium of the marital relationship began to change. While Mr Henderson was away, the mother was able to develop her efficient side at work and also

through having to assume much responsibility for domestic arrangements. When Mr Henderson returned from the war, he found a somewhat different, more determined wife, who was used to shouldering responsibilities. Consequently, after he had failed in his business, he gradually resumed once more the child-mother relationship of his childhood days, becoming somewhat passive and dependent himself, while his wife increasingly took the lead in getting things done. This development was reinforced by his ulcer attacks, and a subsequent operation. Mrs Henderson negotiated the purchase of a house, which in many ways was too much of a financial burden for them. She managed their finances and gradually took over the responsibility for most major decisions. The father settled down to this new adjustment and it looked to the observer as if both found much satisfaction in the roles they were playing to fulfil each other's needs.

Mr and Mrs Abbott (DUI) were a couple who had a great deal of affection and tolerance for each other. Theirs was another marriage where the focus of dominance had shifted markedly from the father to the mother in the course of working out their marital relationship. During their early married life, according to the wife, her husband's main object was to shelter her carefully and keep her 'ignorant', although even then he was inclined to depend on her for advice. Mrs Abbott was rather a shy girl who had been brought up strictly, and knew very little about the world. During the war, when the father was away on active service, she went out to work, mixed with all types of men and women, and learnt much that was new to her about the ways of the world. Gradually, she assumed more leadership in the home, and when the father returned, he seemed content to leave the management of almost everything to her. About their sexual relationship, the mother said: 'I always enjoyed sexual relations with my husband, and was not frightened, although I was so innocent. I always thought it a good thing because he did it to me.' She added that they were still enjoying their sexual life after almost thirty years of marriage. They did not actually share any hobbies or specific interests, but they had a sympathetic understanding of each other's pursuits. The father spent most of his spare time in his workshop repairing and making up wireless sets, and the mother was proud of his craftsmanship. He also bred

dogs, in which the mother took some interest. Mrs Abbott, on the other hand, was an avid reader and sat up late into the night. There was little tension or hostility between them, but an atmosphere of 'live and let live'. For example, Mr Abbott did not consider it his duty to help with the washing up, and this was accepted good-humouredly by the mother. Mrs Abbott felt that the father should have become a manager as the length of his service with the firm, and his skill in his job warranted this, but she was aware that he lacked the necessary 'push'. She was the forward-looking, active planner of the partnership, and was already discussing with her husband how they might keep a little radio shop, which she would start against the time when he retired, so that he would continue to have an interest and a purpose in life.

A few marriages were characterized by a greater equality of partnership than those so far discussed. In these marriages help and support were reciprocal. There was no definite leader, and decisions were taken by whoever was most able to solve a particular problem. This kind of relationship is exemplified by the Brights (DU 25), who are discussed in Chapter IX, pp. 192-3.

There were also a few harmonious and successful marriages in which the father was dominant and the mother had adjusted herself to and fitted in with the father's needs. For example:

Mr Fuller (DU 17) has already been described as a somewhat dogmatic and difficult person, recognized and accepted as such by his wife, who said that they argued but never 'turned nasty'. She shared his interest in gardening and in the countryside. Mrs Fuller also took an intelligent interest in her husband's very technical work, of which she had an unusual grasp.

HARMONIOUS MARRIAGES IN THE CONTROL SAMPLE

Mr and Mrs Hodges (C2) were a striking example of a couple who had assumed roles that fitted in with their mutual needs although these roles were not modelled on the conventional notions of the man going out to work for a wage and the wife keeping the home. Their relationship can only be understood in terms of their early experiences. The mother, a very intelligent,

capable, and somewhat excitable woman, was the daughter of a strict Victorian widow. She felt that during her childhood and youth she had been an unloved Cinderella. She had had to work hard scrubbing and sewing while her mother and younger brother went out to enjoy themselves. When her brother was killed in World War I, her mother said, 'Why couldn't it have been you?' Mr Hodges was a highly intelligent, sensitive, contemplative type of man of considerable maturity. Mrs Hodges 'played him up terrifically' during their courtship because she said she could not believe that anyone wanted her for herself. She refused to marry until Mr Hodges could offer her a home, as she did not want him to live in her mother's house. This behaviour may have indicated a fear that the situation would be re-created in which the maternal grandmother would prefer the man in the house, and put Mrs Hodges into an inferior position. In her marriage she took over the leadership, if only by virtue of her tremendous energy and vitality, which at times seemed inexhaustible to Mr Hodges. She seemed unable to relax and at the age of 50 she was doing a full-time job, as well as a considerable amount of private dressmaking, and her home always looked neat and tidy. It seemed as though her unremitting activity still represented an unconscious response to her mother's admonition to work hard. Mr Hodges, on the other hand, was a quiet person who could relax easily and who liked the peace and quiet of the countryside. Although he often discussed the futility of her continual drive and activity and still tried to persuade her to adopt a more relaxed way of living, he had in fact accepted her as she was, and they had worked out many compromise solutions to suit each other's temperaments. The mother often spent Sunday washing and sewing and sent father out on a bicycle ride in the country. Another week-end the mother would be equally ready to leave her work and go on an excursion with the father. One Sunday they would do something that suited the father's taste—a walk in the country—and another Sunday they would go on a more hectic and exciting expedition into town, which suited Mrs Hodges. These adjustments were not reached without a struggle. It looked as though the mother had worked through many of her childhood problems in the course of her married life, the father being the ever-kind, helpful, mature person who could respond to her needs. At first she

'played up' the father as though to test him. Then for many years she appeared to have turns of psychosomatic or nervous illness. She would keep well for about nine months and then would collapse into dependence and helplessness for about three months. Mr Hodges used to nurse her. He spoke with satisfaction and without any trace of resentment about his nursing role as though it fulfilled a need in him. After her menopause the mother lost these nervous symptoms, and during the last ten years has been fitter than ever before. However, she still continued to drive herself until she almost collapsed and could do no more. At this point she would retire to bed and the father would bring her cocoa and look after her. The parents recognized that they were reversing some of the conventional male and female roles. The father mentioned that his colleagues at work were amazed at the freedom he granted his wife, for example letting her go to dances without him. On the other hand, he did a good deal of the housework. When the mother sat at the sewing-machine wanting to get something finished, the only way to get his tea was to make it himself. The mother on her side said quite openly that she did not like housework and preferred machining. They thought that many of the accepted roles were conventions and that they were happy doing things their way. Each felt a deep affection for the other, and they discussed with animation everything that happened in their lives, neither of them being afraid to voice their opinion, even at the risk of an argument. Seen together, they showed many indications that their differences in temperament were a source of struggle as well as satisfaction. They had quite heated arguments about the mother's insistence on doing the washing at week-ends, and about her excessive work. Yet the mother's initiative and daring aroused great admiration in the father, who by contrast considered himself a rather 'dull, routine chap'. Recently she had started to play the violin and attempted to learn to ride a motor bicycle. The mother, though occasionally exasperated by his placidity, loved the gentle and mature stability of her husband, which presumably symbolized for her a combination of a father she never had and of a gentle, loving mother who would comfort her when she could go on no longer. Their aspirations and values were another important bond between them. In many discussions they tried to work out their aims in the up-

bringing of their children and other basic problems of living. For them this investigation was a stimulating incentive to review their lives together, and to make fresh attempts at working through unresolved problems and difficulties.

Another example of a complementary marriage which was satisfying to both partners, although it may have been built on mutual neurotic needs, was that of Mr and Mrs Bradshaw (c 7).

Mrs Bradshaw had lost her mother early in life, and was brought up by a very intelligent, successful, and possessive father, who expected her to wait on him and look after him as long as he lived. It never occurred to him that she might want to marry. When at work she had to give up all her earnings to him and hardly ever went out in the evenings. Although she resented these restrictions she was deeply devoted to her father and admired him greatly. Her husband courted her for many years. He had had a rough, deprived childhood, and was as dependent and ineffective as her father was dominating and successful. Finally, when she was in her early thirties she married him 'more out of pity than love', having made it quite clear to him that so long as her father was alive, he would come first. They lived in her father's house, and he continued to be the head of the household. Mrs Bradshaw, although she wanted a child, wondered whether it was right to embark on this, in case her father might feel jealous and pushed out of things. After her father's death, Mrs Bradshaw took over many of his roles. She became the 'man about the house' doing the plastering, the papering, and the painting. Mr Bradshaw was not expected to help as he was not considered capable of 'driving a nail in straight'. Through the years he had a succession of illnesses: an ulcer, anaemia, bronchitis, followed by a great deal of invalidism. The panel doctor referred to him as a 'gross hysteric'. Mrs Bradshaw fulfilled the most exacting maternal and nursing functions for him cheerfully until he returned to work. At one time when he had to be at his job at 6.0 a.m. Mrs Bradshaw used to get up at 3.30 in order to get him ready for work and would then walk to the station with him. While she provided this maternal care for her husband, she also gradually built him up to take on her father's role of a tyrant who had to be waited on. Both she and her husband were aware of this development. The husband

discussed how he would have been quite ready to get his own things or hang up his coat, for example, but his wife insisted on doing it for him. Although she never was 'in love' with this man they felt a great deal of affection for each other, and expressed it freely, Mrs Bradshaw saying that they were 'still like sweet-hearts'.

How did it come about that two such emotionally disabled people could give so much to each other? It seems that this immature, dependent man, who lacked maternal love in his childhood, had some of his needs fulfilled by this maternal self-sacrificing wife. She, in order to satisfy her needs, had to keep him a dependent child, thus preventing him from ever growing up emotionally. In this way she was able to serve her husband as she had served her father, working hard and never sparing herself in order to prove herself worthy of his love. (She had had a rival for her father's love in the form of a much more attractive sister.) The relationship also gave her a chance to identify with her father in becoming the superior man in the home who directed all activities from budgeting to plastering. It may rightly be said that both Mr and Mrs Bradshaw were emotionally sick. Mr Bradshaw was a hysteric and Mrs Bradshaw, who was frigid and masochistic, seemed to have considerable unresolved Oedipal problems. It could even be maintained that the relationship was a mutual acting out of their neuroses. But, although the marital relationship was determined by their childhood fixations, it provided substitute satisfactions for these childhood needs and enabled them to lead useful and even happy lives. It is questionable whether any psychiatric treatment of either individually could have done more to help them than the relationship they had worked out for themselves.

Mr and Mrs Brewer's (C 9) marriage represented the kind of relationship in which contradictory aims are revealed. Frustrations were felt on both sides, but strong forces of affection were constantly at work to resolve their difficulties. (Incidentally, this was another case in which the parents took advantage of the appearance of the P.S.W. to reveal and work through some of their differences.) This marriage was rated as a good one in spite of difficulties because of the positive feeling that led the father and the mother to 'please each other', as the son put it. Their choice

can again be understood in terms of their childhood experiences. The mother was greatly attached to her father, a grocer, who had died suddenly when she was in her teens. She had then started to work as a cashier in another grocer's store where she had met Mr Brewer. He, like her father, was a grocer and was described by her as cheerful and easy-going—characteristics also reminiscent of her father. Mr Brewer, whose easy-going optimism and even temper were his outstanding qualities, came from a home where his father, a heavy drinker, was often unkind to his mother. He was intelligent and ambitious, and had become the manager of a shop at twenty-one, and had a great zest for adventure and change. It seemed that he chose a wife who could help him in his business, and provide an antidote for his somewhat impulsive and daring ways of conducting business. Whereas he took risks, Mrs Brewer was of a careful disposition; it was she who kept the books and maintained a close control over the financial situation. The father had very definite ideas that the man should be the leader in the home and he would enjoy, as well as laugh at, the mother's way of waiting on him and the children, calling her 'a martyr who makes herself indispensable' by her constant services. His generosity—and possibly the memory of his father's unkindness to his mother—led him to lavish all the comforts he could think of on his wife. She was gratified by his gifts and said proudly that there was nothing she wanted that he would not give her. Indeed, the home contained all the up-to-date equipment one could wish for. Mrs Brewer had all the clothes she wanted and the smartest car in the neighbourhood. At the same time Mr Brewer felt a certain amount of resentment at his wife's 'martyrdom', which, he maintained, made him feel guilty, at her hoarding activities and her 'blooming houseproudness', and at her need to keep her children close to her. However, this resentment was voiced freely in front of her, and Mrs Brewer put up a fairly spirited defence, remarking on his helplessness in the home and on his untidiness, which she tried to tolerate. She readily admitted her problems over wanting to 'hang on to her children'. This kind of discussion did not appear to be unusual between this couple and they gave the impression that they were able to communicate their feelings and criticisms with comparative ease, and with an underlying feeling of confidence that their relationship could

stand this kind of scrutiny. In the actual course of living together, they had evolved many compromises which allowed them both to satisfy some of their needs. The father was as dirty and messy as he liked in his workshop, and the mother was as clean and obsessional as she needed to be in the living-rooms. Mr Brewer indulged in his relaxation of fishing, whereas Mrs Brewer liked to go to town and look at the shops. But there were also many things they enjoyed doing together. They said that they enjoyed each other's company so much that they hardly ever felt the need to go out in the evenings and seek distraction or meet friends. They were trying to counteract this isolationist tendency by taking dancing lessons together so that they might enjoy dances and official functions more. As their sons were likely to leave home soon they were thinking of taking up golf. When a crisis occurred, as it did over their younger son's love affair, they tried to thrash things out and faced their differences in outlook, which led to heated clashes between them. These differences lay in the father's basic optimism and tendency to rush into things, and the mother's more rigid and cautious pessimism. When discussing this crisis with the P.S.W. they became more clearly aware of the reasons for their different outlooks and the impression was gained that the parents had taken a further step towards accepting each other's differences.

Mr and Mrs Harvey (c 23) had both had deprived childhoods. Mrs Harvey lost her mother when she was 6 and subsequently lived with a variety of relations, which made her feel insecure and unwanted. She preserved a good relationship with her father, who took a great interest in her and of whom she was very fond. Up to his death he remained a very important figure in her life. Mr Harvey lost his father through an accident when he was a child and he was sent to a children's home. He continued to maintain a warm relationship with his mother, who visited him regularly. As both Mr and Mrs Harvey preserved good contacts with and respect for the parent of the opposite sex, it is perhaps not surprising that they were able to build up a good relationship with each other. It is also likely that the similarity of their childhood experiences drew them to each other. Their marriage developed into a peaceful partnership in which everything was discussed and which was considered by both to be a 'fifty-fifty relationship'.

They easily fitted in with each other's needs, and the P.S.W. was aware of very few tensions. They both had a strong desire to build as good a home as possible for their children and, although they lived in one of the roughest and poorest streets in the area, their house could be recognized from afar by its neatly built wall and well cared-for exterior. The father worked long hours in the business he had recently built up, but the mother did not complain. She would provide quiet comfort for him at night, abandoning, if necessary, any plans she had made for going out. He on the other hand was fully aware of her loving care and her qualities as a home-maker. He also praised her efforts to keep herself neat and well preserved. It seemed as though both found profound satisfaction in building up the kind of home for themselves and their children that neither of them had experienced. This may account for the relative absence of selfishness on either side in this marriage.

This review of the harmonious marriages has indicated a fairly constant and somewhat restricted pattern in the DU sample revolving round the theme of 'who shall depend on whom', the wife often taking over the leadership, particularly after her wartime experiences had given her an opportunity to develop her independence and initiative. This fitted in well with the dependent needs so often found in the husbands. Within this general pattern there was much evidence of shared interests, tolerance and adjustment to each other's needs, and respect for individual differences. In the control sample, there was a fascinating variety of marriage patterns, all of them fulfilling in unique ways important emotional needs in both partners. There was the marriage in which roles had been reversed so that the sensitive father with feminine qualities did much of the housework, while the mother took up roles which have a more masculine connotation in our society. Another marriage satisfied strong neurotic needs arising from the partners' unresolved childhood problems. There was the somewhat stormy but positive relationship of two people with opposing temperaments who were making sincere attempts to turn their differences to advantage, and finally the peaceful marriage of two people who had lacked a complete home during their own childhood and who had put all their efforts into the creation of such a home for their children.

OUTWARDLY STABLE MARRIAGES IN THE DU SAMPLE

By contrast with the passing disagreements and antagonisms in the *harmonious* marriages, the *precarious* marriages contained much hostility and tension, which were not regarded as minor difficulties that could be overcome, but which remained chronic sources of irritation, erecting barriers between the partners.

Mr and Mrs Fry (DU 16) have already been discussed in relation to the mother's protectiveness (p. 87) and the father's neurotic and passive traits (p. 121). When seen together they conveyed a vivid picture of their relationship. The mother talked calmly and sensibly about her children, while the father was preoccupied with his own ailments and tried to engage the P.S.W.'s attention. He described at great length his hospital experiences, including quite intimate details, and his wife's embarrassment and slight contempt were obvious. Her attitude was that of a somewhat indulgent and embarrassed mother who appreciates that her three-year-old cannot help behaving as he does. The marked difference between them in emotional maturity and level of intelligence was obvious. For a long time during the research team's contact with the family, the mother remained very loyal to her husband, preserving the attitude of an indulgent mother *vis-à-vis* her pathetic child who is trying to show off. When the father was seriously ill in hospital, the mother at last unburdened herself and confided that she had never been in love with him but married him in order to get out of a hopelessly overcrowded home, and that there had never been any real harmony between them. However, is it not possible that this very maternal woman was attracted to this childish, immature man? Consciously she may have wanted to escape from her big family, but her choice of husband saddled her with a dependent child at the very outset of her married life. Her husband was not only a rather helpless child, but also a truculent one with violent moods. As he was on permanent night work, they could hardly ever go out together, and he was so jealous that he would not even let his wife go to the cinema by herself during the day. She solved this problem by sneaking away secretly to a film with her children. In this and other ways she tried to find a *modus vivendi*, taking it for granted that neither her husband nor her feelings for him were likely to change and that reasonable discussion and resolution of

their difficulties were not feasible. While the father seemed to find satisfaction in his childish dependence and tyranny and also in his engrossing gardening activities away from his wife, the mother found outlets in mothering her husband, in fierce overprotection of her children, and in doing many neighbourly nursing jobs.

Mr and Mrs Morgan (DU 30) seemed a happily married couple. They were both of Welsh origin, and had come to England during the depression. For their twenty-fifth wedding anniversary they had a big family celebration in their home-town. Only very gradually did it become apparent that the adjustment was a precarious one. Both came from strict nonconformist homes. The father in particular had a fierce and overbearing mother who tried to interfere in his courtship and marriage, and caused much unhappiness between the couple. Eventually the father, while still in Wales, took to drinking excessively, which his wife interpreted as a kind of protest against the very strict upbringing he had experienced. For example, she recalled how his mother used to bring a stick with her to fetch him out of the fish-and-chip shop where they were courting, because it was past 10 o'clock. Although he usually gave his wife a certain minimum of housekeeping money, he always kept a high proportion for his own expenses, including drink; occasionally he gambled all his money away on Friday night. They used to have many quarrels and arguments when Mrs Morgan was still hoping to change things; but she had eventually accepted the situation to a large extent. She was able to recognize his good points—his joviality, good temper, and kindness—and she tried to enjoy life in spite of his drinking. For instance, she would not let it spoil her Sundays and went out with her daughter, while he slept off the beer. There was little doubt that Mr Morgan was fond of his wife, who was easier and far less domineering than his mother, and Mrs Morgan felt that in a way she was fond of him. She never seriously considered leaving him although once when he had gambled away all his wages she locked him out. Temperamentally they seemed to complement each other. The father was easy-going, even-tempered, he wished to avoid rows at all cost, and he was extremely friendly and outgoing, talking to anybody he met. Some of these characteristics were reminiscent of Mrs Morgan's father, who was easy-going and lighthearted. On the other hand, the mother became de-

pressed occasionally. She tended to be 'up and down' and did not talk to people easily. It seemed that the marriage had meant a great deal to the father. Although he usually spent all the money he earned, he saved up for months for the silver-wedding celebrations, financing the fares of many relatives and the feast itself. It looked as though the father had found in his wife a far milder and more indulgent version of his mother, because Mrs Morgan took the decisions in the home and was the person who kept things going. She appeared to have been the greater sufferer in the relationship. She enjoyed her husband's easy-going temperament and his company but she had fought a losing battle against his drinking and gambling. These still caused her much uneasiness, which she usually managed to hide; her deepest fear was that her son, who had had some trouble with the police and was inclined to gamble, might go the same way.

OUTWARDLY STABLE MARRIAGES IN THE CONTROL SAMPLE

An interesting process of adjustment in the later stages of married life can be seen in the following marriage, which was rated precarious because of continual struggles and the wife's persisting doubts about her choice of partner.

Mr and Mrs Chambers's (C 13) marriage gave some insight into how parent-child relationships can determine the choice of partner and the shape of the marital relationship. Their marriage can be described as a continual struggle with the forces of their own childhoods. Mrs Chambers felt herself to be rejected by her mother, who preferred her brothers. She reacted to this situation by becoming a determined person who stood up for her rights even in her first job in domestic service at the age of fourteen. Her father, whom she loved very much, she described as gentle, fond of drink, and completely dominated by his wife. It is not surprising that her choice led her to a dependent, mother-dominated man, who courted her faithfully but could not make up his mind to marry her until she issued an ultimatum. She was in continual conflict with her mother-in-law, who was grossly over-protective, and resented the presence of an independent daughter-in-law. Mr Chambers was torn between loyalties to his mother and to his wife, and this struggle between the three of them went on in endless

variations until the old lady died. Since then life between Mr and Mrs Chambers had been more peaceful, but Mrs Chambers has been assailed by feelings that it might have been a mistake to marry this man. She complained how she had to 'push' him and carry him. For example, on two occasions she was instrumental in finding him more remunerative employment when he had got stuck in the rut of poorly paid jobs. One part of her would have wished for a more successful and glamorous husband. But he was the first man who courted her when she was a stranger in London, a rather lonely domestic servant. As she had doubts about her own worth she did not have the courage to drop him and try her luck elsewhere. So throughout her life she went on looking after him and fighting with her mother-in-law for her right to do so. It is possible that in some ways this woman would prefer to be a man: someone who would be valued like her brothers were. Her somewhat unmaternal attitude became clear during a visit when her husband came in hungry after the day's work. After repeated requests, she very reluctantly fried him an egg. He had to make his own tea and find his pudding. This behaviour was in vivid contrast to that of Mrs Austin (D U 2), for example, who on a similar occasion fluttered round immediately getting her husband's meal. The reluctance to take on a maternal role was understandable, as Mrs Chambers herself was continuously searching for a sympathetic mother-figure whom she eventually found in a neighbour many years older than herself. Although Mrs Chambers verbalized her disappointment in her husband in fairly strong terms, she also experienced satisfaction in her relationship with him. There were indications from remarks that both made that they enjoyed their sexual relationship. In many ways she was repeating the pattern of her own mother and took a certain pride in having established her husband in his various jobs. For Mr Chambers the marriage appeared to fulfil most of his needs. He secured another mother-figure on whom he could be dependent and who granted him far greater latitude than his own mother did. His demands were modest; he was not a helpless infant who expected to be waited on. On the contrary, he helped a good deal and accommodated himself to his wife's whims with humour and good grace.

Mrs Briggs (C 12) was one of seventeen children. When her brother brought a friend home she started going out with him. He

was just as quiet and shy as she was. They went to the cinema and hardly ever exchanged more than one or two sentences. They married, Mrs Briggs being relieved to get away from having to look after babies. She had come 'to hate babies' and in her married life she never enjoyed sexual intercourse. Mr Briggs was a conscientious workman and they had a fairly happy and contented life during the first few years, when he was already suffering from a duodenal ulcer. His background had been one of drunkenness and neglect and for the first time in his life he was enjoying regular meals. His gratitude to his wife for this was profound. Gradually his ulcer became worse and he demanded a great deal of nursing from his wife, who sat up with him many a night. Later he developed a serious heart disease, suffered a cerebral haemorrhage, and became a physical and mental wreck. His wife had to take on the role of provider and she worked with fanatical energy late into the night as the forewoman of a little factory whose owner was only too ready to exploit this intelligent and efficient worker. The father's general practitioner felt that Mrs Briggs was unsympathetic and neglectful towards her husband, giving most of her attention to her work. She denied this, and went on working grimly and quietly, neglecting her own health to the point where her doctor refused to take responsibility unless she had a rest. The impression conveyed to the P.S.W. was of someone who was driven by a harsh, relentless conscience to punish herself mercilessly. Her exertions to keep the home going, constructive though they were, also seemed like hostile acts directed against her husband, who was often found sitting miserably with his overcoat on in a dark, uncomfortable, and unhomely room. Mrs Briggs admitted frankly that she did not like housework, and did little in the way of sweeping up and polishing. Yet she also seemed fond of her husband; she told the P.S.W. a curious tale of how they had sing-songs together when he was a little better. There had been no sexual relationship for many years. Mrs Briggs looked young and pretty, but she seemed unaware of her attractiveness. She stayed at the factory every night working herself to the bone. The only glimmer of animation in her face and manner appeared when she talked about her continuous vaginal discharge, and there were dark hints that she might be suffering from a malignant disease. When it was suggested to her that she seemed almost anxious to destroy herself, she

readily agreed, stressing that her whole aim in life was to keep going and remain independent to the very last minute, never permitting herself any respite or dependency on anyone. Her guilt was also evident in her relations to her children. Although she did not want any children, she had two. She was unable to let them out of her sight, took them to work with her, hardly allowed anyone to look at them, and did not send them to school until they were six years old. Unconscious and irrational guilt also seemed apparent in relation to her husband's illness. She felt that she must never allow her husband out of her sight or let him go to work, even if he was capable of it. She felt much easier when he was at home and she could reassure herself that he was all right. One can imagine that this woman's guilt will condemn her to 'forced labour' in their combined prison until her husband's death. It seemed that even if her husband had not become so seriously ill, her loathing of the woman's role would have created a seriously distorted marriage and would have led her to punish herself and others severely.

The examples from the DU sample once more revealed the strong protective wife who was a good home-maker and kept things going. In the control sample, the Chambers's marriage is strongly reminiscent of the DU group though there were important differences in the situation surrounding the marriage. Mrs Chambers was not at all fussy about her housework; she often remarked to the P.S.W., 'You will have to take me as you find me', and both parents were satisfied with somewhat cramped conditions in a small flat. They had no ambitions for a house or nice gleaming furniture, and though Mrs Chambers would have liked her husband to have more initiative she was quite satisfied with her son's achievement as a bricklayer.

Mrs Briggs's leadership also seemed of a different kind. Although she was conscientious, hardworking, and full of initiative, like many wives in the DU sample, she did not combine these gifts with good home-making. The house seemed bare and comfortless, and there was the suggestion made by the general practitioner that she was unsympathetic and neglectful towards her husband. Yet, these precarious marriages show similar problems in both samples. One or both of the partners seemed to have such severe, unresolved childhood problems that the marriage partners could not fulfil the resulting unrealistic and often contradictory demands

made on them. In some of the marriages rated as harmonious, there were also wives and husbands who carried over unfulfilled needs from their childhood into the marital relationship, but the choice of partner—conscious or unconscious—was such that these needs were complementary and could be adapted to the realities of the adult marital situation, or else the partner was an exceptionally stable and mature person like Mr Hodges (C 2). In the harmonious marriages the partners also seemed more evenly matched in regard to intelligence and values, which made sharing and discussion of problems more possible, whereas in the precarious marriages many discrepancies in these respects were encountered. In the latter marriages, the choice of partner was often presented as a means of escape from an intolerable situation (an overcrowded home, lonely domestic service), while such pressures were seldom mentioned by the more happily married couples.

BROKEN MARRIAGES IN THE DU SAMPLE

Five marriages in the DU sample failed completely, compared with four in the control sample.

These failures are dealt with briefly because breakdown in marriage receives a good deal of attention in the Press, in the literature on delinquency and on the social problem group, and in general discussions on social pathology. On the other hand the patterns of stable marriages, which constitute the majority in both samples, are rarely discussed and studied.

No common pattern could be detected in the DU sample; each breakdown tells its own story.

Mrs Clayton (DU 8) was married to a man who was said to have been unfaithful and cruel, but, according to her son, the mother herself went off with another man. It was difficult to disentangle the true picture because the mother did not appear to be very truthful and the father was dead. According to the mother he was excessively 'lustful', wanting intercourse at all times of the day and night. He appeared to have been a dominating man who used a strap on his children. It is possibly a comment on this marriage that in her second marriage the mother chose a borderline mental defective who was sexually quite undemanding, and whom she despised.

Two marriages seem to have broken down because the wives were not ready to assume their full feminine roles.

Mrs Booth (DU 14), whose parents were unhappily married and later separated, was a very effective, intelligent, and vivacious woman who was married to a slow Yorkshire man. She was frigid. The 'easy come, easy go' ways of her husband exasperated her and she left him without any clear-cut reason when her baby was a year old. She enjoyed her 'freedom' as a single woman and her son was cared for by her mother. Eventually she re-married, choosing a man who was more effective and sophisticated than her first husband and with whom she had much more in common. However, her sexual difficulties and her difficulty in 'fitting in' and giving up her independence presented serious problems that almost led to a break-up of this marriage as well. This time, helped perhaps by her contact with the Unit, she was able to discuss her feelings and to gain some insight into the forces that were driving her towards 'packing up', and she remained with her husband.

Mrs Cross (DU 7) married to escape from an unhappy home ruled by a dominating, highly erratic, and alcoholic mother who had driven away a dreamy, intelligent, and artistic husband. Mrs Cross, however, was quite unable to break away from her dependency on this forceful mother. She was frigid and unwilling to meet what she thought were excessive sexual demands from her husband. A few months after the birth of a child, Mrs Cross left her husband and returned to her mother. She had never again been able to establish a home of her own, and had left her son in her mother's care. For many years she remained dependent on her family for home comforts while she worked in domestic jobs. At the time of contact she was living with her married brother and had not even got a room to herself. Her bond with her mother was still strong although the latter was dead. She visited her grave often and thought she could sometimes hear her voice.

The two other marriages, that of Mrs Harris (DU 13) (see p. 208) and that of Mrs Dale (DU 18) (see Appendix II, p. 263), cracked

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under the strain created by one excessively abnormal, if not psychotic, partner.

BROKEN MARRIAGES IN THE CONTROL SAMPLE

The broken marriages in the control sample seemed to have been the result of similar strains.

Mrs Atkins (C 14) was an extremely efficient woman who could not bear her drifting, feckless husband, and they separated after six years of married life.

Mr and Mrs Blake (C 3) presented a painful example of a completely frustrating, neurotic marriage. Mrs Blake suffered from recurrent dyspepsia and neurotic fears; she was frigid and was also somewhat self-righteous in her attitude. She was a hard worker and had become exasperated by her husband's inability to keep a job, and by his selfishness and preoccupation with himself. She nagged him a great deal and was unable to show any compassion or sympathy for him. He also appeared to be severely disturbed, being absorbed in the functions of his body and complaining of many symptoms. Their difficulties started early in their married life when they separated for three years. They came together again but have lived in a state of constant friction ever since. Mr Blake was still reaching out towards his wife, asking for sympathy and sexual gratification, but was always rebuffed by her and told to 'pack his case' at least once a week. It is perhaps significant that Mrs Blake was able to look after a lonely old-age pensioner in her street with great devotion and tenderness.

Mr Bridges's (C 24) 'marriage' was an irregular union. After his first wife's desertion he lived with a girl many years his junior who produced two children. According to him, she was a good mother, but immature, and she eventually went off with a younger man. The father was a thoughtful man who had been fond of this girl and was deeply puzzled as to why two women should have left him. The impression gained was that he might have been sexually inadequate in some way.

Finally, there was the forced marriage of two reluctant people,

Mr and Mrs Bailey (C 4). Trouble arose because Mr Bailey was more devoted to his mother, to whom he gave the housekeeping money, than to his young wife. There followed a five-year period of separation ending in a reunion. They had several more children, but apart from sharing one roof there appeared to be no affection or bond between them. Mr Bailey drank heavily and took little notice of his wife. He was unfaithful to her and Mrs Bailey expressed the fervent hope that one of these days her husband would go off and leave her. Mrs Bailey was described earlier as a seriously disturbed woman who could not express affection for her husband and children or look after them in a reasonably protective way. The home looked bare and dilapidated and the children presented many problems.

All these severely disrupted or broken marriages demonstrate the incompatibility of needs which shows up most clearly in relation to sex; for example, the passionate husband or wife who was repulsed or unsatisfied by a cold or reluctant spouse. This happened in at least six of the marriages. But the incompatibilities also extended to other social and emotional needs; for instance the quick efficient person who was frustrated by the slowness of his or her partner, or the weak immature man or woman who needed a strong, mature parent-figure to lean on and who found a mate unable to take on this role. This frustrated search for a parent substitute in the marriage relationship, which seems related to the sexual failures just mentioned, was perhaps the fundamental cause of disruption. Related to these signs of emotional and sexual immaturity may be the phenomenon that in six of these disrupted marriages one or both of the partners were seriously disordered personalities who might have been incapable of a permanent relationship with anyone. The frustrations and disagreements and the cumulative hostility in the nine disrupted marriages seemed so severe that they destroyed most of the affection and goodwill between the partners and made a solution or a working-through of their difficulties an impossible undertaking. In most of these marriages the incompatibility of aims between the partners appeared to be so great or their disturbance so severe that even with skilled and timely help these marriages could not have developed into mutually satisfying relationships.

How do these observations fit in with the answers to the question Gorer (1955, p. 138) put to the readers of *The People*: 'What do you think goes to wreck a marriage?' The five reasons most frequently given are—lack of trust, selfishness (no give and take), no house of one's own, temper, sexual incompatibility. The first two and the fourth items are all clearly signs of negative or hostile feeling of which there was much evidence in the unsuccessful marriages in both samples. Sexual incompatibility has also been mentioned as an important factor. Having no house of one's own was given as a reason most frequently by those couples who shared a house with their mother or mother-in-law and may be associated with the emotional immaturity so marked in most of the nine marriages. There may well be a connection between the presence of mother or mother-in-law and a wrecked marriage, but need it always be the direct or primary cause? Is it not possible that the emotionally more dependent and immature couples make less effort than other couples to establish themselves independently, and thus unconsciously invite the proverbial interference of the mother or mother-in-law? Thus the views *The People* readers held on the causes of wrecked marriages highlight most of the incompatibilities, which also seemed of importance in the disruption of the marriages in these two small samples.

What conclusions can be drawn about the marriages in the DU sample and about the ways in which they differ from those in the control sample? What can we learn generally about the patterns of marriage in both samples?

1. The women in the DU sample reached their dominant position in the marital relationship by a variety of routes, and not only because of their own needs, but also in response to the strong emotional needs of their husbands. The wartime experiences of these women contributed significantly to this development. There were many variations on the theme of dominance and submission, ranging from the 'good fit' of needs in the harmonious marriages, through the precarious balance in the less satisfactory marriages where the mother's dissatisfaction and occasional contempt *vis-à-vis* her husband were outstanding features, to the broken marriages where the disparity between the partners proved too severe altogether.

2. In the control sample, while the theme of dominance and submission also figured conspicuously in some marriages, the relationships between the spouses were worked out in far more varied ways.

3. Some tentative general observations can be made on the various patterns of marriage that emerged in the course of the study. In the free and therapeutic atmosphere of the interviews with the families, much emotional stress was revealed in marital relationships. However, these stresses and strains were often balanced by profound emotional satisfactions which the spouses provided for each other. It sometimes seems that these satisfactions are overlooked by social scientists and social workers when they comment on the stressful nature of modern marriage. The marital lives of most of the couples may be undramatic when observed purely from the outside, but they did not convey that drab and humdrum quality mentioned in sociological descriptions of modern urban life (Slater and Woodside, 1951, p. 148). Indeed the richness of feelings expressed, the varied ways in which emotional and other satisfactions were sought, and the healing and constructive power of affection, which overcame quite serious conflicts, were inspiring to observe. An impression was also gained that a considerable proportion of the women were less frigid and uninterested in the sexual aspects of their marital relations than some investigators and many women themselves suggest (Slater and Woodside, 1951, p. 273; Stiber, 1954; Gorer, 1955).¹ There is a hint in the material that the more active mothers in the DU group were possibly more vigorous and active in their sexual lives than the mothers in the control sample. (Only in rare circumstances was the sexual relationship discussed in any depth with the fathers, who were seen less often).

Finally it was found, as in other investigations, that often choices of partners and the ways in which the relationship is worked out in marriage can be understood only if one relates them to the earlier interpersonal experiences of the spouses, mainly

¹ 'English men tend to the belief that women's interest in sex is as great as, or greater than, that of men; English women on the contrary consider that the physical aspects of sex mean less to them than to their menfolk . . . 16 per cent of the men and 26 per cent of the women agree with the statement "Most women don't care much about the physical side of sex"; 55 per cent of the men contrasted with 39 per cent of the women disagree with it' (Gorer, 1955, pp. 114-115).

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to their relationships with their parents (Dicks, 1953; F.D.B, 1954).

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CHAPTER VIII

The Childhood of the Young Men

How did the children in the DU sample respond to the attitudes they encountered in their parents, and what kind of children were they? We found a wide range of personalities and behaviour, from the mischievous, restless, and delinquent roamer, to the anxious, quiet, and solitary child who never left his mother's side. However, the pilot studies suggested that the DU patients displayed certain typical emotional attitudes in their relations with their parents and contemporaries in childhood, and led to the expectation that the control sample would be different in these respects. Examples of these typical attitudes were also seen in the three detailed case-studies, and included the following:

The Expression of Aggression

Parents and school-teachers often described the DU boy as quiet and well behaved. They frequently reported that he was unassertive and avoided fights and other kinds of overt aggressive behaviour. If displayed, aggression in these children was reported to be sudden and explosive, and limited almost entirely to speech.

Relationships with Parents

The DU boy had a close and often ambivalent tie to his mother and a somewhat more distant relationship to his father, which seemed related to the mother's dominance, protectiveness, and restrictiveness on the one hand, and to the father's unassertiveness on the other.

Relationships with Peers

The DU boy seemed to have difficulties in making friends outside the family and to be less involved in his friendships than the children in the control sample.

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The Dependence/Independence Conflict

The DU boy often seemed to show conflict between his desire to keep close to his mother and depend on her, and his strivings to emancipate himself from her influence.

Two series of questions were explored in addition:

Achievement

There is a prevailing notion that people suffering from duodenal ulcer are ambitious and want to rise in the world. Is this borne out by the scholastic achievement of the boys who later develop ulcer? Are they more industrious scholars than the boys in the control sample? Do they win more scholarships? Do they distinguish themselves by other achievements such as becoming leaders of formal or informal groups?

Health in Childhood

Have the boys in the DU sample suffered more ill health than the control sample? That is to say, did they have more neurotic traits, psychosomatic disturbances, or organic illness than the boys in the control sample?

THE EXPRESSION OF AGGRESSION

Two-thirds of the DU sample, twice as many as in the control sample, were reported to have avoided fights and other aggressive activities as much as possible, and were generally described as quiet and well behaved. While half the boys in the control sample were ordinarily aggressive and mischievous, this applied to only one-sixth of the DU sample. No numerical differences were found among the boys who were described as markedly mischievous and aggressive.

Table 19 LACK OF OVERT AGGRESSION IN CHILDHOOD

	DU	Control
Lack of overt aggression (no fights, quiet, well behaved)	21	9
Ordinary aggression (some mischief, naughtiness, fights)	6	17
Marked overt aggression (much mischief, fighting, defiance)	5	6
Total	32	32

The boys in the DU sample who were rated as non-aggressive were commonly described in terms such as these: 'quiet, never wanted to fight'; 'did not like boxing'; 'very quiet, passive, never wanted to fight'; 'very quiet—too quiet—though he fought with his brother'; 'not enough go in him, he was reserved, shy, and quick-tempered, and did not fight'; 'never fought, more like a girl'; 'cried easily about children hitting him, very quiet'; 'quiet, reserved, afraid of other boys'; 'timid, tidy and particular, gentle and girlish, not a leader, had dolls in his pram'; 'a quiet child, very feeling, never heard a bad word from his mouth, cautious, not daring'; 'never told who to play with, but chose select, superior boys'. Eleven of these boys had 'very dominant' mothers of whom eight were either restrictive or over-protective or both. Four mothers were rated as 'dominant', and three boys had driving and restrictive fathers. It is of interest that in their psychiatric interviews six of the twenty-five non-aggressive boys gave a different description of themselves as children from that given by their mothers to the P.S.W. They talked about 'being in mischief', having been 'rips', 'scrapping', 'always doing things we should not'. There are several interpretations that would explain this discrepancy. These mothers may have described their children as they wished them to be. Alternatively, the mothers may not have been aware of their sons' more aggressive behaviour outside the home, which they may have concealed as much as possible. Some of the young men, in their desire to appear tough and independent, may have seen themselves as more 'boyish' and mischievous than they really were. It is worth mentioning, too, that four of the boys in the DU sample as against one in the control sample were described by their mothers as 'girlish', and played with dolls or preferred to play with girls.

The eight markedly unaggressive boys in the control sample were described in terms very similar to those used for the un-aggressive boys in the DU sample: 'very quiet'; 'unable to stand up for himself, not confident'; 'not much fighting'; 'quiet boy, not a great fighter, timid, thought of as a cissy'; 'used to get as far away from a fight as he could, more like a girl, would play with dolls, cry easily when hurt'; 'shy, lacking in confidence, not aggressive or pushing, though temper tantrums when small'; 'very shy, never mixed up in fights, frightened of others, very mild and

forgiving'. Five of these boys had an environment similar in some respects to the DU boys, because their mothers were dominant or restrictive and protective. They had not developed ulcers, but they did suffer from considerable personality difficulties. One consulted his doctor about a 'fluttery stomach' and indigestion, and had a phase of obsessional hand-washing in childhood. Another had such severe anxieties that he was unable to pass an examination, suffered from frequent headaches, worried about his blood pressure and complained about 'butterflies' in his stomach. Two more were excessively shy and anxious during childhood and adolescence and were very 'mother-bound'. The fifth was the son of Mr and Mrs Briggs (C 12) whose marriage was described in the preceding chapter. The boy was following in his mother's footsteps; working very long hours, doing two or three people's work, allowing himself only a few hours' sleep at night. Although this intelligent and gifted young man will probably go very far, the team felt that he might have to pay a heavy price in terms of psychosomatic or neurotic illness. His problems were thought to be severe enough to require psychiatric help.

Boys were rated as 'ordinarily aggressive' when they were on the whole conforming, got into mischief occasionally, were able to stand up for themselves or to engage in fights with other children when occasion demanded, and were not described as particularly quiet or submissive. The following comment would characterize ordinary aggression: 'active, never seeking fights, but able to stand up for himself'. Only six boys in the DU sample compared with seventeen controls had attracted comments such as 'harum-scarum, mischievous, did not like fighting'; 'ordinary amount of mischief' (and then the mother would quote incidents); 'occasional fights'; 'never rowdy but keen to explore and roam, though not much fighting'; 'very active and noisy, at first unable to stand up for himself, but learnt later on'; 'mischievous, many larks but not particularly naughty'; 'active, out with the boys, not much fighting, enjoyed being the leader'.

The descriptions of their games and escapades in childhood that the young men in the control sample gave to the psychiatrist often contained remarks to the effect that their mothers did not mind their coming in late or dirty so long as they did not 'get into

trouble'. The parents' greater easy-goingness and lack of fuss were again implied in these comments.

The number of boys who showed evidence of much fighting and rebellion and an excessive amount of misbehaviour is the same for both samples. However, their background and later development indicate that the same kind of external behaviour does not necessarily imply a similarity of experience or personality.

One boy in the DU sample, Geoffrey Morgan (DU 30), was described as 'independent, cheeky, and mischievous'. On leaving school he drifted from job to job and became thoroughly unruly and beyond his parents' control. After committing a minor larceny he was put on probation and later, following a more serious offence, he was sent to an approved school. Cecil Clayton (DU 8) was described as a tough boy who was always involved in fights, had to be 'top dog' with other children, and was disobedient and stubborn at home. He was caught stealing at the age of eleven, but committed no further delinquencies after that. A third boy, Ralph Davies (DU 9), was rated as markedly aggressive although on several occasions his mother insisted that he was a quiet and well-behaved, if moody, boy. On the other hand, she related some accidents that are not consistent with 'quiet' behaviour. He fell off a lorry to which he was holding on, and he was twice injured by branches when climbing trees. She was the mother mentioned before as non-protective, who seemed to be ignorant of crucial happenings in her children's lives, let them fight their own battles, and for a long time in her contact with the P.S.W. minimized the serious tensions in the family. In the circumstances the boy's description of himself as a child seemed nearer the truth; 'always in some sort of mischief, fighting, chasing and riding horses, holding on to lorries, often coming home with torn trousers, getting into trouble'. He committed serious larceny in late adolescence and was sent to Borstal. These three aggressive and delinquent boys experienced somewhat unsatisfactory and incomplete relationships with their mothers. The first, Geoffrey, was evacuated for the longest period of any child in the DU sample, six years. His mother felt extremely guilty about this long break, during which she went out to work and for the first time enjoyed a socially active and financially comfortable life. (Her marriage and her difficulties over her husband's drinking and gambling were

described in the previous chapter.) Cecil's mother deserted him during childhood and he was sent to a children's home for a year. The strangely 'blind' and placid attitude of Mrs Davies (DU 9) to her children has already been described. Equally important, these three boys had very unsatisfactory fathers. Cecil's father was a bullying type who used the strap frequently; the other two fathers drank heavily and neglected their families. These observations on the restlessness and aggressiveness of delinquent boys are well in accordance with the findings of the Gluecks (1950, p. 274) and of Stott (1950, p. 352). The unsatisfactory nature of the relationship with the father has perhaps been stressed less in recent years, but is revealed quite clearly in Stott's material (see Appendix VI).

The remaining two boys rated as aggressive in the DU sample seemed to be different. One was reported to be restless, mischievous, and always in trouble at school. He, however, denied in his psychiatric interviews that he was as mischievous and troublesome as his mother had painted him. Unlike the three delinquent aggressive boys, he was the son of a very managing, restrictive, and protective mother. She seemed to enjoy recounting her son's mischievousness almost as though she was proud of it. Perhaps she wanted to prove to the P.S.W. that she was not so controlling after all? The fifth boy was described as very aggressive, argumentative, and excessively disobedient. His home situation has been discussed in several other contexts (Mrs Cross (DU 7) see p. 94, 153). His mother left his father when he was 5 months old and he was brought up by an autocratic, erratic, and alcoholic grandmother, with whom he fought incessantly. The aggressive behaviour of these two boys took the form of arguing with and defying their frightening and authoritarian mothers. It may be of interest that when seen at the Unit both the young men were not only critical of their mothers but markedly paranoid.

The very aggressive boys in the control sample were a much more mixed bunch. The only serious delinquent among them was Leonard Freeman (C 26, p. 205). He was described as a 'devil, often in mischief, who truanted a great deal'. He was found to be beyond the control of his parents and sent to an approved school. He later served two prison sentences for various offences. His relationship with his parents, however, seems to have been a comparatively happy and undisturbed one. Two other boys developed a

strong antagonism to their mothers, whom they felt to be lacking in understanding. Both these boys were very jealous of siblings whom they believed, quite correctly, to be preferred by their mothers. The fourth, Tony Atkins (C 14), was the son of a very restrictive mother. He had spent some years between the ages of 5 and 9 in private children's homes although he was always able to see his mother at weekends. When he was reunited with her he was very defiant and full of mischief, stayed out late, and occasionally truanted from school. His behaviour seemed to be an open active rebellion against his mother. The two DU boys who attempted to rebel against their mothers never stayed out late or truanted, nor did they engage in any definite antisocial behaviour. Tony, however, continued to lead a wild life, drinking and chasing after girls until he finally married.

When he was seen at the Unit, he seemed to have 'settled down' to being a good husband to a young wife who was in every respect the complete opposite of his mother. Tom Hammond (C 11) was described as someone who flared up easily, was cheeky and 'lippy', the noisiest and most aggressive youngster in a large and very happy family. He was verging on the antisocial in his rowdy, adolescent, gang activities. He did not appear to be seriously disturbed when seen at the Unit, but there was evidence from his mother's account and from his own interviews and tests that his toughness covered a good deal of insecurity and anxiety about his state of health. Finally, Cyril (C 8) told yet another story. He was described by himself and his mother as a 'pest' when small; always up to mischief, messy and defiant, very disobedient, and destructive with his toys. His mother was an extremely obsessional woman (see Appendix II, p. 267) who seemed unable to cope with a spirited youngster. This was illustrated by her stories of how her attempts at controlling the boy were criticized by her doctor. When this boy grew older and attended a grammar school, he became very studious and solitary and at the Unit he revealed considerable difficulties in handling his relations with other young people.

Reviewing the pattern of aggressiveness found in both samples it seems that many of the children who develop duodenal ulcer later in life have difficulty in expressing what might be called an 'ordinary' amount of assertiveness. This behaviour is readily

understandable on the grounds that the conscientious, careful mothers and the steady quiet fathers discourage any expression of aggression, and also on the grounds that the mothers are on the whole so 'good and powerful' that the boys would want to comply with their wishes. Those boys in the DU sample who showed marked aggression in childhood had mothers who were not as 'good' as those who succeeded in keeping their sons' aggressive drives in check. This applied to a lesser extent in the control sample as well.

Another interesting contrast was that six mothers in the control group reported temper tantrums in their children's early lives. Only one mother in the DU sample related how her son developed serious outbursts of rage after experiencing several traumatic events in puberty.

The apparent lack of aggression in a considerable number of boys in the control sample is also worthy of comment. Almost one-third were described as somewhat unassertive, obedient, and quiet. Many others expressed their dislike of fighting or other aggressive activities, which is in contrast to prevalent notions of the unrepressed, cheeky new generation who were brought up 'to do as they liked'. It is well in accord, however, with the findings of a study carried out on eighteen-year-olds in a similar borough (Logan and Goldberg, 1953) and with Gorer's central hypothesis that a strict social conscience holds potentially strong instinctual aggressive forces in check. He suggests that this 'self-control' may be partly the result of the early imposition of discipline, the earliest manifestation of which is the 'gentle, patient but insistent training in cleanliness'. It may also be a consequence—Gorer thinks—of the heavy parental censorship on the expression of anger or hate (Gorer, 1955, p. 293). These boys are not to be thought of as 'cowed' or afraid of their elders. Their behaviour as conveyed by the parents and by the boys' own stories seems to contain elements of 'gentleness' and conformity; the result possibly of the growing identification of boys with their mothers rather than their fathers, even in the control sample, and of an increasing orientation towards their parents that is a corollary of smaller families. This trend is more pronounced in the DU sample, where two-thirds were markedly unaggressive. In this respect, as in others, the DU sample seems to present in an exaggerated form patterns of living and

behaviour that are also evident, though to a lesser degree, in the control sample.

RELATIONSHIPS WITH PARENTS

Relationships between the Boys and their Mothers

The majority of the mothers in the DU sample exercised a great deal of anxious care in bringing up their children, which seemed designed, unconsciously at any rate, to keep the boys close to them. Most of the boys in the DU sample responded with outwardly compliant behaviour to the mothers' careful training. In Peter and Michael—two of the boys in the detailed case studies—this compliance was accompanied by attitudes that may be described as 'passive resistance', a kind of subtle revolt against the mothers' over-protective or restrictive régime. This behaviour may indicate one aspect of the dependence—independence conflict that is so often said to be present in the adult DU. Thus it is possible that a close attachment exists between the majority of the boys and their mothers, and at the same time a certain amount of veiled hostility on the part of the boys towards their mothers. These suggestions find some confirmation in the case material.

Table 20

NATURE OF RELATIONSHIP WITH MOTHER

	DU	Control
Strong attachment and overt dependence	10	7
Ambivalent tie and evidence of struggle for independence	13	6
Warm relationship, neither dependence nor independence emphasized	8	18
Not known	1	1
	—	—
Total	32	32

Both the similarities and the differences in the distribution of attitudes displayed in this table are of interest. Nearly as many boys are closely attached to and dependent upon their mothers in the control sample as in the DU sample. On the other hand, twice as many DU boys showed ambivalent attitudes. Finally, over half the controls as against a quarter of the DUs seemed to have ordinary warm relationships in which neither undue closeness nor strong ambivalent feelings could be detected.

The first category consisted of children who kept particularly close to their mothers and were very dependent on them. For instance, the child who till he was 13 held his mother's hand on going out; the boy who sat on his mother's lap when he was already quite big; the lad who was always ready to do housework and paper-rounds for his mother; the child who clung to and accompanied his mother wherever she went; the boys who could not bear evacuation and by hook or by crook got themselves back to their mothers. During childhood, at any rate, these boys did not betray any desire to rebel against this close tie. Later, however, some showed openly critical and ambivalent attitudes towards their mothers.

Leo Foster (D U 22) was convinced that he was his mother's boy. There was a very close bond between them and he helped her in many ways, doing the housework and going on paper-rounds to give her extra money. When he was 16, his mother died, and he left home as he felt that there was 'nothing left to live for' there. He could not bear to enter the empty house without his mother present, and he was quite clear that he would never have left home if she had lived. His strongest desire was 'to be worthy of Mum' and live up to her ideals. Mrs Foster was one of the most maternal and indulgent mothers in the D U sample (p. 93).

Norman Booth (D U 14), whose parents separated when he was one year old, was brought up by his maternal grandmother, with whom he was in the position of an only child who 'could do as he liked'. She died when he was 15. He became very depressed and developed his ulcer. He then went to live with his mother, who had meanwhile remarried, but he was unable to make a good relationship with her or his step-father. She was as ambitious and restrictive as his maternal grandmother had been indulgent and easy-going. He was highly critical of her and felt she did not supply what he needed. On one occasion he complained bitterly that the dog had better food than he had and in many other ways he had a feeling of being deprived by her. He was longing for the tasty West-country dishes his grandmother used to make, which his diet forbade him to have. He wanted to

be taken care of in the way his grandmother had done, for she had let him have anything he wanted and not interfered with anything he did. In his mother's house he was 'made to toe the line', he had to fit in with step-brothers, take orders from his step-father, help with the housework, and live up to the exacting standards of cleanliness and efficiency his mother demanded. Eventually he left her and made his home with his paternal grandmother, clearly hankering after the lost paradise, where he would again be the only child, whose every wish would be gratified.

It appears that these boys experienced the mother or mother substitute as a good, powerful, and 'ever-giving' figure who supplied all their needs, to whom they surrendered completely, and on whom they remained deeply dependent, without apparently feeling the need to strive towards some independence. In adult life some repeated the pattern by marrying, or courting, generous mother-figures on whom they could lean and make demands, while still keeping in close contact with their own mothers.

There were also examples of this type of close and dependent relationship in the control sample.

Max Hodges (c 2) was the elder son in the family described in the last chapter in which the parental roles had been reversed. He had always been a very 'cuddly kid' and 'one for Mum'. On first starting at the infants' school he squeezed through the gate and ran home to his mother. When he was evacuated he sat in a chair, refused to eat or undress, and had to be fetched home after a day. When he saw his mother he 'clawed her all over' in what she called a 'fit of hysterics'. He was an accident-prone child, daring and impulsive, in spite of his great dependence on his mother (or perhaps because of it—she herself was a very impulsive person who rushed into things and had several minor accidents during her contact with the Unit). During adolescence he developed a skin condition that did not yield to treatment for years, and recurred whenever he was upset or worried. He remained close to his mother in adult life and was considered by himself and other members of the family as very much like her in temperament: impetuous, cheerful, with a great zest for living,

a love of speed, and an immense capacity for work. His ties to his mother began to loosen when he served in the Army, and later he was able to work away from home for months at a time, though on his return he would always find his mother first, and never come without a bunch of flowers. He discussed his problems, and particularly his love troubles, with her and also with his father. He was especially concerned because he always seemed to lose interest in a girl after a few months of friendship.

Fred Bull (C 17) was another small boy who clung to his mother, would not let her out of his sight, and held her hand in order to go to sleep up to the time he went to school. Even at the age of 17, he sat on her bed when he came home from a dance, and told her all about the day's happenings. One night when he was waltzing with his mother in her night-clothes, showing her the steps he had learned at his dancing-lesson, his father tried to protest only to be told: 'Leave us alone, we are having a good time.' Fred's mother, like the mothers of Bob and Max, was a very dominant woman who ran the affairs of the family very efficiently and who took a great interest in Fred's schooling and choice of job.

Of these seven who were so strongly attached to and dependent on their mothers, six had very dominant mothers and the seventh a very protective and indulgent one. It is again interesting to speculate how these boys in the control sample managed to solve their problems of dependency, which looked so similar in childhood to those of the DU boys. The three examples just quoted and the histories of the other four show that these youngsters seemed able gradually to loosen their ties with their mothers while still remaining on very positive and friendly terms with them, preserving much that was valuable in the relationship. There were some remarkable instances of the sharing of experiences, discussion of problems, and easy-going companionships between the growing son and his mother which in some cases extended to the father as well. It is possibly significant that four of the seven mothers of these overtly dependent boys were out at work compared with two of the ten DU mothers whose boys were closely attached to them. By spreading their interests and energies more widely the mothers in

the control sample were perhaps better able to let these boys grow towards independence despite their own dominance and forcefulness.

On the other hand the ten closely attached and dependent boys in the DU sample did not seem able to work through their dependency on their mothers in a similar manner. Either they had a need to perpetuate as completely as possible the state of demanding babyhood like Norman Booth or Derek Allen, or more frequently they came to resent their dependence in adolescence and felt irritation with their mothers, though they were still demanding much attention and gratification. There was little indication of discussion and sharing of problems. Instead, a kind of split in the relationship seemed to occur so that at one and the same time it contained an element of resentment and a kind of demanding dependence. These demands were often continued in their relationships with their wives. Indeed far more of the overtly dependent boys in the DU sample had fiancées or were married at the time they attended the Unit than in the sample as a whole. This was not so in the control sample. Thus it seemed that whereas the boys in the control group were able to convert their close attachment and dependence on a powerful mother into an affectionate, but emotionally less dependent companionship, which still allowed them to receive much valuable 'nourishment' from their mothers, the DU boys and their mothers could not change their relationships in this constructive way.

The thirteen boys whose relationship with their mothers was overtly ambivalent form two clusters: those in whom negative feelings were predominant (four) and those in whom both positive feelings and negative attitudes were expressed (nine). The four boys with predominantly negative feelings towards their mothers felt rejected by them. They were boys who had either experienced physical, or some form of emotional, separation from their mothers; for example

Cecil Clayton (DU 8) was nine years old when he was admitted to a children's home for a year, as his parents had separated. He said that he developed a hatred for his mother when he felt abandoned in the home. He had suffered earlier separations from her at the ages of 6 and 18 months, and it is possible that his

violent reaction to his later separation was nourished by his earlier experiences. He had always been a very aggressive, independent child (p. 163), who would never show any tender feelings or let anybody know that he was in pain. It may well be that this tough behaviour was designed to shield him against the pains of separation and unhappy family relationships generally. He developed a strong attachment for his landlady, praising her for her good food and care, which is perhaps an indication of his persisting need for a mother-figure.

The mothers of these four boys were mentioned as lacking maternal protectiveness (p. 90), and the boys' independence, their toughness, and their refusal to show any tender feelings or to confide appear to be defences against further risks of being rebuffed.

In the nine instances in which both positive and negative feelings were expressed, the mothers were generally felt to be good providers, but the boys resented their nagging, probing, and fussing, and often responded with stubbornness and secretiveness, which became more pronounced during adolescence. Examples of this kind of behaviour were seen in Peter Brown and Michael Cohen among the initial case studies.

Another similar case was Donald Cameron (DU 6) who was left in the care of his maternal grandmother for a year at the age of 9 months (p. 67). She was much more easy-going than his careful and conscientious mother had been. On return to his mother, he showed some signs of stubbornness and independence in connection with toilet training, which she started. This streak of independence remained with him throughout childhood. For example, if he would not eat his food, and the inducement to eat was the withdrawal of the sweet course, he would not put himself out to get the sweet, but preserved an attitude of indifference. At the outbreak of war he was evacuated to relatives in Scotland, where he was very unhappy and often cried himself to sleep. He never showed his distress to anybody. After his return there were clear signs of resentment towards his mother, but he has never been able to admit that he missed his mother when he was away. He continued to keep things to himself and resented his mother's talkativeness and probing, and

seemed unable to allow himself to express openly his need for her when he was ill.

There were several other boys who preserved a similar kind of closeness about their feelings; who seemed to be on their guard, as though they were defending themselves against the onslaught of their mothers' prying and controlling efforts. The mother frequently commented that their boys 'did not confide'. Yet the boys also liked their mothers' attention and this often kept them at home in quite close daily contact with their mothers.

In the control sample only six boys expressed openly ambivalent feelings, but with one exception their problems did not seem to centre on the probing, pushing mother. This exception was Tony Atkins (C14), who has already been described as a markedly aggressive boy; and he was rebelling against a striving, over-efficient mother, who was anxious to make him into an obedient and industrious boy. Three boys felt themselves rejected by their mothers, who seemed to prefer a young brother; in two more cases, the ambivalence seemed to be related to insecure family relationships engendered by somewhat immature or neurotic mothers who lacked confident warm motherliness.

One of them was Cyril Cox (C8), already described as markedly aggressive (p. 165), the child of a highly obsessional and anxious mother who from early childhood seemed unable to control him. There were many stories about his rebelliousness, as a toddler, his refusal to let his mother cuddle him and his many struggles with her in adolescence. He was irritated by her uninformed chatter and by her lack of sympathy and understanding for his intellectual aspirations. (This is in great contrast to the DU sample where mothers were always in sympathy with their sons' ambitions.) Yet there was a close bond between them. Even as a young man he would let her wash behind his ears. He loved her food. He took her to the university football matches and she was the only mother whose son invited her to ride in the bus hired for the students. In a family argument he felt that basically he was always on his mother's side.

It is not surprising to find that four of the six boys who had openly ambivalent relationships with their mothers revealed

considerable emotional conflicts when they were seen at the Unit.

In the DU sample eight boys appeared to have relationships with their mothers in which there were no obvious signs either of undue dependence or of ambivalence. It is perhaps significant that in seven of these families the father exerted a strong and important influence, being admired by the son and having a positive relationship with him. Five of the mothers were of the non-dominant type and another two had assumed a dominant role in response to external circumstances. A high concentration of ulcer among close relatives was also found in several of these families. In five of the eight families either a parent or a grandparent had a peptic ulcer. In the three cases in which there seemed to be no genetic predisposition, the relationships of the sons with their mothers, although outwardly undisturbed, appeared to contain considerable frustrations that might have resulted in strong ambivalent feelings in the sons.

The mother of Colin Grant (DU 31) suffered from T.B. during most of his childhood and he experienced frequent separations from her; so that even when she was at home he was not able to cuddle and kiss her. Both father and son maintain that she was 'all he could want for as a mother', and the relationship between son and mother was described as an easy, friendly, non-restrictive one. However, it does seem possible that the child felt somewhat anxious and even hostile towards his mother who was forced to frustrate him so much. It is also understandable that he could not allow these feelings to enter consciousness.

The situation of Alec Ellis (DU 19) was more complex. He felt that his mother had been permissive and generous during his childhood and she described him as a 'sweet', 'charming', 'well-mannered' boy, whom she had never any cause to punish as he was so well-behaved. There is, however, evidence that the mother, who had serious problems about sexual matters, felt revolted by the idea of breast-feeding and, often let the baby wait for hours for his feed if there were other people in the house, as she felt too embarrassed to suckle him in their presence. She had very strict notions about swearing and cleanliness, and was one

of those mothers who felt compelled to make up for her initial rejection by over-indulgence and the giving of many presents. This made it difficult for Alec to acknowledge any kind of negative feeling he might have had about her restrictive activities. He was not allowed to play in the street or to choose his own friends. His father was strict and much admired. Alec seemed to cope with his mother's conscience by developing a similar kind of conscience himself. The mother related with pride how he would 'always take the blame' and would insist on sharing everything with other children. If he received a penny it had to be changed into farthings. If he was given an orange he would always divide it among his friends, and once when he saw another child being punished by its father he kept saying, 'I wish he had hit me.' It seems clear that a boy with this kind of conscience could not allow himself any overt criticism of his mother.

The childhood situation of Paul Baxter (D U 20) was different again. Circumstances forced him to remain loyal to his mother when perhaps he too had experienced frustration and strong ambivalent feelings. He was the eldest of a large family. His father was a difficult man who often accused the mother of doing more for her children than for him. Although there is evidence that the mother did not devote a great deal of time to her children and liked going out to work, Paul always felt that he had to defend her against his father, and the outward relations between himself and his mother had always been friendly and easy.

In the control sample, eighteen boys were thought to have a warm relationship with their mothers.

Eric Harvey (C 23) said of his mother that she used to give him a reasonable amount of freedom, that he was able to go out and find his own friends, and that she never tried to probe into his activities. When he first started to earn his living she helped him to buy his clothes, but she also helped him to become independent and handle his own money. This young man stressed how, if any of the family were ill, his mother would nurse him or his siblings without the slightest thought for herself, and would not leave the young ones in the pram but would try to have them with her.

Other boys felt that their mothers had given them freedom while also providing security; as one put it 'she gave us safety hints'. The son felt her motherly qualities and was aware of the security in the relationship when he discussed his childhood with the psychiatrist. He also seemed aware of freedom to grow in the way he wanted to, and freedom to learn and find things out for himself.

The information available from both mothers and sons suggests that among the dominant mothers those who combined protectiveness with indulgence tended to evoke a close dependent relationship in their sons. On the other hand those mothers whose protectiveness was mainly restrictive in character, while also keeping their children close to them, were more likely to stir up in them resentment and strivings to free themselves from this control.

Although warm, but generally 'looser' kinds of relationships were found between the majority of sons and mothers in the control sample, over one-third of the sons had close ties to their mothers that were at times very intense. This too may be a reflection of social changes already mentioned that enhance the mother's prominence in the home, not only as home-maker, but as organizer and figure of authority, who may thus be in danger of unwittingly binding her son too closely to her.

Wartime Evacuation

In considering the children's relationships to their parents, and particularly to their mothers, it may be revealing to study their reactions to evacuation, an experience to which the majority in both samples were exposed.

Table 21

EVACUATION

	DU	Control
Children of school age in official evacuation area	26	28
Evacuated with school	13	18
Evacuated to relatives	4	3
Evacuated with mother	7	2
Mother unwilling to let them go	2	2
Not evacuated for other reasons	—	3
Not living in an official evacuation area	4	3
Aged 14 in 1939 and started work	2	1
Total	32	32

The table shows that the evacuation experiences of the children did not differ very much in the two samples. The only interesting difference is that seven DU families compared with two control families evacuated together, that is to say, the mother went away with her children and was occasionally joined by the father. This may suggest once more that the mothers in the DU sample had a greater need to hold on to their children than the mothers in the control sample. It appeared that this was more a problem of the mothers than of the children, since almost equal numbers in both groups were very seriously disturbed by their evacuation experiences. Unfortunately there is insufficient detailed information about the children's behaviour or their emotional reactions during evacuation to throw any light on their developing personalities. There are perhaps more comments about unhappiness and homesickness among the children in the DU sample than among the controls (DU 13, c 7).

Relationships between the Boys and their Fathers

The main characteristics of the boys' relations with their fathers have been discussed in Chapter VI. Stress was laid on the easy, friendly, brotherly type of relationship prevalent in both samples. The father as a feared figure of authority had virtually disappeared. However, particularly in the DU sample, this friendly 'sibling' relationship was not strong enough to be an effective counterpart to the mother's dominance or to help in resolving conflicts with her. Several of the DU patients commented on the way in which their fathers contracted out of any family quarrels and let the mothers have their own way for the sake of peace, the boys being conscious of a lack of support from their fathers.

Other suggestions arise from a closer review of the relationships between the sons and the fathers. In families where the mother was dominant, a kind of relationship that might be termed 'indifferent' often occurred (DU 15, c 8). In these cases the young man felt that he had never had much in common with his father or had little contact with him. The father was rarely mentioned in the interviews with the psychiatrist, or his worth was depreciated by the young man.

Very few boys in either sample, about five in each, had clashes with their fathers. Some of these conflicts occurred over job

choices, others because the boy disapproved of the father's way of life (drink in one case, and unreasonable treatment of the mother in another). In only one case did the conflicts arise because the boy would not fit in with the father's disciplinary régime. This surely is a comment on the changing pattern in the father-son relationship.

Subtle differences between the two samples could be detected among those boys who got on well with their fathers and shared similar views, work, or hobbies. In the DU sample a feeling of fondness or companionship was often expressed, but it was rare for a boy to accept his father, wholeheartedly, to feel that he was like his father, or to want to follow in his footsteps. This kind of positive identification was revealed much more clearly in the control sample. For example, the youngest boy in a family where all the male members went to work in a transport undertaking like their father became a van boy on leaving school. One boy carried a photograph of his deceased father—a jovial semi-skilled worker who had loved his beer—in his wallet, and was becoming more and more like him in manners and habits. Another boy, who had always confided more in his father than in his mother, was eagerly receiving instruction in carpentry from his father in order to make furniture for his own home. Yet another young man felt that he was like his father, sharing many interests with him, and saying that he 'wished to follow in his footsteps'. An interesting example of family 'belongingness' and identification with the paternal tradition was Gerald Glover (c 18). He was of very superior intelligence, had matriculated, and had started training for a profession. But he, like his brother, chose to return to his father's and grandfather's trade, in which his father was respected as a prominent trade union man. There was the son of a heavy drinker who defended his father in family rows; the boy who worked with his father in his business and shared the same hobbies and was said to be like him in every way; the boy who used to attend all kinds of sporting events with his father, and felt greatly at a loss when his father died; the young man who admired his father for taking so much interest in bringing up his children, developed a very close relationship with him during adolescence in the London blitz, and, on leaving school, decided to learn the same trade.

In the DU sample this kind of positive identification also occurred, but among fewer boys and sometimes with some reservations; it was especially wholehearted among those whose fathers were very successful at their job. An interesting example was the relationship between Rex Austin (DU 2) and his father. Earlier it was described (p. 114) how this father explicitly delegated all the disciplining of his son and major decisions about his welfare to the mother. He took a great interest, however, in his son's artistic activities, being something of an artist himself, and he gave him much valued criticism. His son admired him very much and thought that he had a 'wonderful brain'. There was also the son of an ambitious father, Mr Fuller (DU 17) (p. 117), who was still attending evening classes in his forties. Though he did not confide in his father, and had been rather frightened of him in his childhood, he chose a similar career, engineering, and discussed many of his work problems with him. An example which is reminiscent of the control sample, was the son of another ambitious and very successful father, a highly skilled craftsman who had become the manager of a small toolmaking firm. He followed his father's trade, although he never fulfilled the latter's expectations by gaining further qualifications at evening classes. Yet another very successful father, who rose to be a manager at a very early age, had a son who admired him profoundly and followed in his footsteps by becoming a chargehand in the same trade at the age of 17.

RELATIONSHIPS WITH PEERS

It is difficult to assess the relationships of the boys with their brothers and sisters as this issue rarely came up in the interviews, except where it presented a specific problem. The relationships with contemporaries outside the family seemed to play a much more important part in their lives, and this applied to the larger as well as to the smaller families. A striking feature in the DU sample was the attempt of a number of boys (9 out of 24 with siblings) to vent their aggressive feelings on older or younger siblings and to dominate them. Often this behaviour suggested a displacement of their aggressive feelings which they dared not express towards their mothers, a phenomenon very clearly observable in their relations with their sisters. For example,

FAMILY INFLUENCES AND PSYCHOSOMATIC ILLNESS

Ronald Fry (D U 16) was full of complaints about his younger sister and fought with her on every possible occasion. She was felt as someone who ordered him about, and he thought she was getting more attention from his mother than he did. James Henderson (D U 5) used to dominate his sister in childhood, although she was two years older. In other respects he was a gentle, non-aggressive child who cooperated well with other children. Several other children took up a somewhat moralistic attitude towards their younger siblings about homework or about their general behaviour, which seemed a barely concealed attempt to imitate their mothers.

This pattern of dominance and moralizing in sibling relationships was not found in the control sample. Sibling rivalry was more often expressed in open jealousy and envy. For instance, Bernard Curtis (C 25) was very upset when he saw his newly-born sister occupying his cot, and at first he refused to have anything to do with her. He remained jealous of her and envious of her greater intelligence and success at school. Simon Bailey (C 4), an illegitimate eldest child, always felt the odd man out and was convinced that his mother preferred the next brother, who was legitimate. His feelings were expressed in envy and withdrawal from the family, rather than in any attempt to dominate his younger brother.

RELATIONSHIPS WITH PEERS IN CHILDHOOD
AND ADOLESCENCE

	DU	Control
Solitary, no friends	7	3
Some friends, spasmodic group activities	14	15
Very sociable and popular, much involvement in group activities	11	14
Total	32	32

This table shows that the proportions of very sociable and moderately sociable boys were similar in the two samples. There were no major differences in the nature of the relationship or the kind of activities in which the boys engaged. Certain stereotypes emerged from the information obtained in interviews. To be popular and have friends have become highly prized virtues in

our society, and it seems that both the mothers and the children strove to present a rosy picture of their popularity. As might have been expected from their protective environment, there were a few more solitary boys in the D U sample, children who had very few friends or none at all. The circumstances of their solitary existence varied. Two were rejected children who have already been described: Jack Cross (D U 7), whose parents were separated and who was looked after by his alcoholic grandmother. He was solitary and uncommunicative as though he was defending himself against the bewildering insecurity of his environment. Charles Gilbert (D U 3) also had an inadequate mother and had to fend for himself. His favourite pastime during evacuation was to wander over the moors by himself. In addition there was Donald Cameron (D U 6) whose ulcer appeared in childhood, and who for this reason could not share in the activities of other boys. However, he too had experienced some rejection and separation, and his story conveyed the picture of an apparently depressive withdrawal similar to that of Charles and Jack. Solitary habits were also encountered among those boys whose mothers restricted their choice of friends. Six of the seven solitary boys in the D U sample were considered to be seriously emotionally disturbed at the time they attended the Unit. Similarly, all three solitary boys in the control group had serious neurotic difficulties at the time of contact with the Unit.

About equal numbers (D U 14, C 15) were reported to have several friends with whom they went out to play. Boys in this category often belonged to Scouts or the Boys' Brigade or other clubs for a short time without becoming seriously involved in their activities. Eleven boys in the D U and 14 in the control sample were described as very sociable and popular. They were much sought after, deeply involved in their chosen activities, took much interest in their clubs and games, and made lasting friendships.

Another phenomenon that may be of significance is that four boys in the D U sample but only one in the control sample were reported to have played with girls rather than boys and to have shown an interest in girlish pastimes.

It is difficult to interpret the findings relating to childhood friendships. The unhappy, isolated children stood out in both samples and appeared to be heading for emotional disturbances in

later life. It was perhaps puzzling to find that the boys in the D U sample are reported to have mixed almost as well as the children in the control sample. The current practice of encouraging relationships with peers and the importance attached to the ideal of 'popularity' may provide some explanation. Since the mothers in the D U sample were particularly conscientious and anxious to do 'the right thing', it is quite possible that they encouraged friendships and 'mixing' in spite of their unconscious needs to hold on to their children, which found expression in other subtle ways. For instance, the children in the control sample ventured much farther afield; often they were said to have roamed freely and gone for rides all over London, whereas the D U boys kept mostly to their immediate neighbourhood.

ACHIEVEMENT AT SCHOOL

Do the children in the D U sample, who are so often sons of ambitious parents, show any conspicuous drive towards achievement at school? In order to answer this question a comparison was made between intelligence levels of boys in both samples in relation to their effort and achievement at school. No evidence was found to suggest that the boys in the D U group were more ambitious or industrious than the children in the control sample although they were on the whole more exposed to parental pressures.¹ Eleven D U boys and the same number of controls won places to either grammar or technical schools (grammar school: D U 6, C 8). Since the distribution of intelligence test scores was so similar in the two samples, there can be no suggestion that in the D U sample scholarships were obtained by a marginal group who worked extremely hard to attain this level. Of the eleven in the D U sample who obtained scholarships, six were able to make full use of their opportunities and became seriously involved in their studies. One matriculated and trained to be a solicitor. One attended an art school and was continuing his studies while working at a studio. Three were reading for a degree, and one was teaching at his technical college while taking further training. Of the remaining five,

¹ There were, however, some indications that an appreciable change took place after adolescence, and this will be discussed in later reports on the adult personalities of the D U patients (see also Appendix I).

two did not take up their scholarships on account of poverty and evacuation respectively, two left the grammar school before taking School Certificate, and one failed in his post-school studies.

In the control sample the proportion making full use of their opportunities was similar (5 out of 11). Two were reading for a degree, and three were aiming for higher technical qualifications. Of the other six, two did not seem interested in scholastic success or higher technical training, and one, though highly successful at school, married so young that he could not afford further training. However, he was soaring to success in his career. These figures also indicate that the amount of upward social mobility in the two samples was similar, and it seemed probable that two or three in each sample would become established in a profession.

In considering the relation of measured intelligence to type of school attended, the number of intelligent boys who did not attend grammar or technical schools is also of interest. Six boys in the D U sample and nine in the control sample did not win a place to either grammar or technical schools, although when tested in their late teens and early twenties they possessed full-scale I.Q.s of 112 or more. Of these only one in each sample pursued additional technical training at evening classes. This observation suggests that in both samples there was an untapped reservoir of talent that for some reason had not been spotted and developed at school (Gray and Moshinsky, 1938). It is a further indication that the D U children did not make any greater use of their innate abilities or achieve more in their school careers than the control sample, although their parents were on the whole more ambitious.

HEALTH IN CHILDHOOD

On the whole the boys in both samples had enjoyed good health although most of them suffered from the usual childhood ailments. Seven boys in each sample had more serious illnesses, including appendicitis, pneumonia, ringworm, rheumatic arthritis, and nephritis. As for their mental health, it has already been shown that the D U boys had greater problems in handling their aggression, particularly in relation to their mothers, and that there were more solitary children among them. However, there was

hardly any difference between the two samples as to evidence of childhood neurosis or behaviour problems. Six boys in the D U sample and five in the control sample showed signs of serious disturbance in childhood, such as persistent truancy, delinquency, great difficulties in making relationships with other children, and manifestations of severe anxiety.

Most of the eleven seriously disturbed boys have already been mentioned because their family relationships have been discussed in various other contexts; the over-protection or rejection by their mothers, the marital difficulties of the parents, or the children's strong dependence on or ambivalence towards their parents. Their family backgrounds thus revealed many of the patterns of family relationships so frequently associated with the emergence of emotional disturbance in childhood. The main point of interest here, however, is the similarity of the proportions of children with serious emotional disturbances in both samples. In other words, it appears that children in the D U sample were no more likely to suffer from serious emotional disturbances than the general run of schoolchildren in that area. Unfortunately the information on the prevalence of neurotic disturbances in children in Great Britain is very meagre. The prevalence of serious disturbance appeared to be similar to that found in a recent study of twins attending schools in South London (Shields, 1954). Such considerations lead to the tentative conclusion that the emotional conflicts of the D U patients may become overt only at a later stage—possibly when they have to leave the shelter of their homes—or that they may never reach consciousness.

Table 23 shows no essential differences between the two samples, except perhaps suggestively in the two items connected with aggression: temper tantrums and nail-biting. Whereas the children in the control group showed more overt aggression in the form of temper tantrums, the children in the D U sample seemed to express more oral aggression directed towards themselves in the form of nail-biting. It is just possible that the incidence of psychosomatic symptoms reflects a trend that would be more apparent with larger numbers. In the D U sample, two boys had asthma in childhood, one alopecia, one acidosis, and the fifth had attacks of sickness from the age of 3 which grew worse when he started school. In the control sample three boys were reported

Table 23 NEUROTIC TRAITS, PSYCHOSOMATIC
SYMPTOMS, AND BEHAVIOUR DIFFICULTIES IN CHILDHOOD

	DU	Control
Fears and anxieties	10	9
Bed-wetting	4	5
Nail-biting	12	8
Sleep disturbances	1	2
Feeding difficulties	0	2
Obsessional symptoms	1	1
Stammering	1	1
Temper tantrums	1	6
Psychosomatic symptoms	5	3
Travel sickness	2	1
Accident-proneness	0	1
Delinquency	1*	1

* Two more DU boys became delinquent after leaving school and are therefore not included in this table.

to have had symptoms that may have been psychosomatic: one developed a skin rash towards adolescence, one had persistent stomach pains from early childhood, and one had headaches and bilious attacks.

To summarize the childhood experience of the DU patients: it is clear that in many important respects they did not differ greatly from the children in the control sample. They were similar as regards the state of their physical and mental health, their achievement at school, their friendships, and their activities generally. There were some differences, however, in the ways in which they expressed their feelings, particularly their feelings of aggression, and in their relationships with parents and siblings. The DU boys were closely tied to their mothers, and this tie often contained veiled hostility towards them. While they might have had a close relationship with their fathers in early childhood, this seemed to become less important in later childhood and adolescence, and as a result they identified less with their fathers than did the boys in the control sample. In their relation with their siblings many adopted a characteristically dominant or aggressive attitude, whereas the controls tended to show the more usual patterns of overt sibling rivalry and jealousy.

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CHAPTER IX

The Families Their Functioning and Cohesion

In the foregoing chapters the main emphasis has been on a particular person or relationship, though the family setting has been kept in mind, while in this section the main focus will be on the functioning of the family as a whole. The question will also be raised whether there is anything specific about the 'personality' and make-up of the D U families to differentiate them from the control families. Some differences between the two may be expected because certain characteristic balances of forces have been discovered not only in the marital relationships but also in the mother-child and father-child relationships. A greater amount of psychosomatic illness has been noted among the parents of the D U children. On the other hand there were no differences between the D U families and those in the control sample regarding open disruption of marital ties. These facts as well as the very close family relationships in two of our three case studies would not lead us to expect a dramatic lack of cohesion in the D U families in contrast to the families in the control sample. Rather, the D U families may emerge as closely knit units, characterized by relationships that contain certain tensions beneath a well-functioning surface of 'cosiness'. From the knowledge gained about the parents' high standards of behaviour and conscientiousness and the mothers' ambitions, more social ambition might be expected in the D U families.

CRITERIA USED IN ASSESSING FAMILY FUNCTIONING

It is difficult, in the present state of knowledge in social psychology and with the, as yet, crude tools of measurement, to assess the functioning of a small group such as a family, especially as no attempt was made in this study to observe the functions and roles of all members of the family on a systematic day-to-day basis. However, enough material was gathered on all members of the family concerning their attitudes and their activities to attempt a classification of these families as well- or poorly-functioning units on the basis of some rough general criteria.

The first criterion chosen was the balance between love and hostility within the family. This does not imply that a 'happy' family would show an absence of tensions or hostility. However, for a family to function as a harmonious group, bonds of affection need to be strong enough to engender cooperative attitudes, a 'pulling together' in its main activities and mutual support in any crises. This cooperation can never be merely an intellectual process a kind of 'social contract' in which members of the family agree to adopt certain roles and functions. The springs of cooperative action and support must be of an emotional kind—a desire to give and receive love—in order to fulfil the basic emotional needs of the members in a family group.

The second criterion, which is already implicit in the first, is the effectiveness of communication between the members. It does not seem necessary that the members of the group should be actually together for the major part of their activities, or that they should always share them. It is essential, however, that the members of a family should have sufficient sympathy and interest for each other to exchange information, so that there is always present a common pool of knowledge uniting the members of the group. It is thus possible to visualize a well-functioning family in which members have many varied and quite separate interests, but in which there is sufficient communication and interest in each other to provide a feeling of mutual understanding and sharing, through discussion at the meal-table, for example. A family in which the pressure to communicate is so intense and the bonds are so tight that nobody has any 'secrets', and activities and interests are shared or expected to be shared in all circumstances, is not

considered to be a well-functioning unit. The channels of communication and sympathy provided by a well-functioning 'elastic' kind of family are a source of support as well as an incentive for individual growth and development, whereas the 'tight' or rigid family tends to strangle individual growth.

This leads on to the third criterion, which is the sharing of some basic values among members of the same family. If, for example, some members pursue ideals of learning and aesthetic satisfaction at the expense of material satisfactions and comforts, and others make material values their main aim in life, a clash will occur, which, however great their affectionate bonds may be, will make living together a very stressful experience. This sharing of basic values is of particular importance because parents provide 'role models' for their children. If parents present incompatible values to their children, then the attempt to identify with them may lead to painful conflict within the individual members of the family and between them.

An attempt has been made to assess the functioning of the families in both samples on a four-point scale. Families were considered to be *functioning well* when they engendered ties of affection and co-operative attitudes among their members, particularly in crises when they would 'pull together'; when communication between members led to an easy sharing of information and to a resolution of tensions; and when common ideals were shared. Families were considered to be *functioning fairly well* when most of the positive attitudes just described were present, but hostilities and tensions were never quite resolved and smouldered underneath a cooperative surface, and when these antagonisms interfered with communication between the members. Families were considered to be *functioning poorly* when the home was regarded as a place where you 'hang up your hat'; when there was little evidence of mutual co-operation or pulling together; when each was going in a different direction with little contact between the members and little sharing of common ideals. Finally there were the families considered to be *disrupted*, in which a parent was absent and children left home at the earliest opportunity. It does not follow that these families functioned worse than the ones in the third category. Indeed the open disruption of stressful ties may lead to a healthier readjustment on a new family basis.

Table 24

COHESION OF FAMILY

	<i>DU</i>	<i>Control</i>
Families functioning well	7	13
Families functioning fairly well	14	10
Families functioning poorly	5	4
Disrupted families	6	5
Total	32	32

If all outwardly united families are taken together there are no differences between the two samples. When more subtle distinctions are introduced, small differences do emerge with more well-functioning families in the control sample. On the other hand almost half the *DU* families belong to the category of families functioning fairly well. In view of the stresses already observed in the marital and parent-child relationships such results were not unexpected. However, it is possible that since the contact with some of the *DU* families extended over a longer period of time it brought to the surface stresses that remained concealed in the control families.

In addition it is necessary to take into account the possible bias introduced by the replacement of the six families in the original sample of control subjects who failed to cooperate. Some information about these six families was available because the P.S.W. had at least one prolonged interview with the parents of five of them, while the psychiatrist saw the son of the sixth. The general practitioner supplied additional very useful information. None of the families was broken by divorce or separation. One seemed to fall into the category of 'families functioning poorly'; the father was drinking and gambling and working only intermittently and everyone seemed to be going his own way. Four of the remaining five families were easy-going and somewhat less 'respectable' and responsible (e.g. they did not keep hospital appointments or cooperate with the general practitioner) than the majority in the control sample, but they seemed to be reasonably happy family units engendering a good deal of affection and loyalty among their members. The general practitioner characterized three of them as 'an ignorant lot with no social sense'. The fifth family was a closely knit unit, very similar to others in the control sample. It is thus unlikely that the inclusion of these families would have

altered the findings on family cohesion. Indeed they would have probably brought out greater contrasts still between the DU and the control families in regard to the mother's conscientiousness, the father's unassertiveness, and the general drive towards respectability (see Appendix III).

Before illustrating the findings with some case examples, it is worth noting that none of the well-functioning families in the DU sample bore the influence of a 'very dominant' mother. In three families there was an equal partnership between the two parents. In two the father was the leader, and in one the mother had risen to leadership relatively late in the family's life. In the seventh family, the mother had died of tuberculosis when the patient was 16 years old. She was an obsessional and dominating woman, but because of her illness and the many years she had spent in hospital, the father became the central figure in the boy's life. In six of these seven families, a parent or grandparent had a diagnosed ulcer, possibly an indication that in these well-functioning families a genetic factor played a somewhat greater part in the aetiology of the son's ulcer than in the more disturbed families.

FAMILIES FUNCTIONING WELL

The Castle family (DU 24) consisted of father, mother, and an only son. The father, who had a DU, held a steady job in public transport. The mother had never worked outside the home and was a warm homely person who always had a cup of tea ready. Her home was comfortable without being fussily tidy. The parents shared everything. 'If there was only one sweet in the house, we would break it in half.' There was trust between the three of them, for example they would go to each other's purses. Despite their feelings of affection and trust they were not demonstrative. Bill was encouraged to bring in friends, and although the parents were seen as indulgent by the son, they had not been afraid to exercise a certain amount of control. Their common values became very apparent when Bill married into a very different kind of family. Among his in-laws there was much tension and quarrelling, purses were kept hidden, the family lavished kisses on each other, and no control was exercised over the children. Bill's marriage proved difficult because of the clash

of values and because the young wife turned out to be an immature, extravagant, spoilt child. The Castles stood up well to this challenge. They welcomed their daughter-in-law and tried to understand the different kind of upbringing she had experienced. Although they were deeply concerned over their son's wellbeing, they would not encourage him to be disloyal to his wife. In other families in similar circumstances, the parents might have tried to entice their only child back to the parental shelter, or they might have rejected him if he intended to remain with his wife. The security and flexibility of the Castles was such that they were able to absorb this problem and to make an attempt at resolving it. Discussion with their son and, what was more, a warm acceptance of the daughter-in-law and a subtle way of teaching her their family values by example seemed gradually to forge a bond between parents and daughter-in-law. Towards the end of the contact with this family, it seemed as though its members had been enriched by the experience of learning to accept someone with a very different background and values.

The Bright family (DU 25) consisted of the parents and four children. The father was an easy-going and intelligent foreman; the mother a capable, conscientious person who suffered from gastric ulcer and periodic attacks of migraine. The marital relationship was one of sharing, and roles were flexible as occasion demanded. For example, the father would usually help with the washing up but the mother would never consider it a question of 'must' or of unalterable routine. The children grew up in an atmosphere of affection and moderate control. On many occasions the P.S.W. saw one or other of them coming home from school, when they used to tell their mother the main happenings of the day in a free-and-easy manner. They would help themselves to a snack and fit in easily with the atmosphere of the visit, neither attempting to occupy the centre of the stage nor creeping shyly into the background. The household seemed to run smoothly; the mother was never rushed, or unready to receive the P.S.W. Members of the family gave the impression of enjoying life. Owing to the mother's illness, they often had to rally round in mutual help and support. When the mother was admitted to hospital for gastrectomy the eldest girl gave up her job to keep house, the father did the washing at the week-end, and the children

tried to do their bit. One did not sense any strain during these weeks. On the contrary, father and daughter got a certain amount of fun out of doing unusual duties. The wedding of the DU son took place during the time of contact, and did not cause any special fluster. The courtship had lasted about two years and the daughter-in-law was warmly accepted. In this family everyone had special interests. The mother felt that women should have an evening away from home; she spent it with a woman friend. The father had his evening off playing bowls. The eldest girl was involved in many church and club activities. During the time of contact the DU patient was busy courting; but in earlier years he had been much involved in evening classes. The two school-children belonged to Cubs and Brownies. Although everyone was pursuing different interests there was much discussion and interchange of information in the family circle, which enabled this family to have contact with many activities in the outside world.

Although the DU families just described, and others in the same category, conveyed warmth and affection, yet there was an undefinable atmosphere of restraint, 'niceness', and respectability about them. Their lives seemed to be cast into certain well-defined moulds. In the control sample on the other hand the variety of patterns met in well-functioning and cohesive families was again impressive as was the greater display of unrestrained feelings.

The Baker family (C 1) consisted of mother, father, and an only son. But how different they were from the quietly cosy Castle family. On entering a small, unpretentious little terrace house, the P.S.W. found strewn about the sitting-room Chester Wilmott's *Struggle for Europe*, *Venture to the Interior* by Laurens Van Der Post, and a book by Cecil Beaton, all of which turned out to be the father's reading matter. On another visit he was found listening to 'The Critics'. He was a man of high intelligence and wide tolerance, a decorator on his own account, with no ambitions to expand his business as long as he could make a comfortable living and enjoy his varied interests. His wife, an unprepossessing, plump little woman, was very downright in her approach and never made any special fuss of the P.S.W. She was intellectually her husband's inferior, but she had a rich personality. She enjoyed her job as a part-time capstan-lathe operator, getting a kick out of surpassing the output of the younger girls. She gained much

satisfaction from her visits to her parents in the country. Her sense of beauty was strongly developed and she astonished the P.S.W. by a vivid and almost lyrical description of the Welsh countryside. She had taken up fishing with her husband and both derived a great deal of enjoyment and fun from this pursuit. The son, although an only child, was encouraged in his independent striving; he was allowed to go out and explore the town as a child but they also engaged in combined family expeditions. He was quite able and willing to get his own meal if he came in late—no anxious mother sat up for him. There were lively arguments and discussions between the three of them and good-humoured tolerance of differences. Again, there was diversity of interests, but sufficient sharing and communication to make this little group cohesive. Their values were also basically alike. Mrs Baker, for example, did not press her husband to expand the business and make more money, nor was she at all distressed that her only son became a labourer. 'As long as he gets something out of life it is all right.' The father, on the other hand, did not criticize the mother's interest in her work although it sometimes resulted in a scrappy lunch and not much housework done.

There are many ways in which cooperative functioning can be expressed in a family circle:

Mr Evans (C 27) had a small business of his own and his wife ran a little newsagent's shop. The son was following their example in wanting to establish himself in his own business. When he felt the need to discuss his love affairs with his parents they were rather taken aback but they sat up many a night with him trying to sort out his difficulties. Again, a problem of differences in values was at stake. This family were typical provincial shopkeepers of Conservative convictions and the daughter-in-law came from a left-wing working-class environment. They all made serious attempts to get to the essential problems of human relationships that lay behind the conflict of values. For instance, they discussed how the girl had grown up in a big family in which there was disunity and poverty; how she had to struggle to achieve her present position; how on the other hand Philip had grown up in an economically secure environment much protected and 'spoilt' by his mother. Thus the parents felt it was understandable that the girl was somewhat envious that everything had fallen into Philip's lap

and that she felt he was not making enough effort, either vocationally or in his personal relations with her. The family also discussed Philip's guilt about having had everything easy and his attempts to prove himself worthy in the eyes of the girl. In trying to disentangle these complexities, the parents and Philip had begun to re-assess their values and to show much more tolerance towards the different way of life and values of the prospective daughter-in-law and her family. Again the impression was gained that though this small family unit was held together by very close bonds these were sufficiently elastic to encompass new experiences.

The Brewer family (c 9)—the somewhat turbulent marriage between an optimistic, generous father and a more pessimistic, cautious mother has already been discussed (pp. 142-3)—themselves considered that they were almost too closely knit. Both sons joined the father in his business and the mother helped with the book-keeping. They were a happy-working community. The father was worried, however, lest he had protected his sons too much. 'They are standing on my shoulders.' The mother missed them badly when they were away in the Forces, and wrote to them every night. When one of the sons was jilted, the family rallied round and he was able to join their activities for a while before he was ready to pick up with outside friends again. The family enjoyed doing things together, going on holiday or on week-end outings. It remains to be seen how the two sons will be able to emancipate themselves and build up a life of their own.

Finally, it is interesting to consider the cohesion of an outwardly rather drab and sad family beset by much illness:

Mrs Bartlett (c 10) suffered from gallstones and menopausal depression. The husband was ill with a serious heart condition. A single daughter had severe neurotic difficulties, and had no friends outside the family. She was deeply attached to her father, on whom she waited, and she was a companion to her mother. Much ill luck had come to another daughter, as her husband was found to have T.B. and her two children also became infected. The family were helping them in every way they could in spite of the handicaps of their own serious illness. With much difficulty and persistence they achieved an exchange of houses for the daughter, so that she was nearer to her parents who could then support her more effectively. This family demonstrates that if the affectionate

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ties are strong enough the family can overcome severe handicaps and extend help to the weakest member in a crisis.

The common feature in these well-functioning families is their flexibility, the way in which members of the group provide support where and when it is needed, at the same time leaving members free to develop their own personalities and interests.

FAMILIES FUNCTIONING FAIRLY WELL

Families that function less well often communicated a sense of strain beneath an apparently cheerful and calm surface. About half the DU families were found in this category and the strains often emanated from difficulties created for the family by the restricting or possessive mother at the centre. In these families the flexibility just described was lacking. Instead there was a certain rigidity that did not help to resolve crises but rather kept them in a chronic 'sub-acute' state. The closeness and apparent cohesiveness of such families often had a restricting and strangling influence on the emotional growth of the members, whereas the truly cohesive family had the capacity to encourage individual growth. This point is illustrated by the following three examples:

The Franklin family (DU 4) consisted of the parents, two sons, and a daughter. The father and mother were closely attached to each other. The father humorously accepted his wife's highly-strung temperament which he called 'hysterical' at times, adding, 'It would not do for both of us to be the same'. He died during the time of contact with the Unit and was sadly missed by his wife. Mrs Franklin ran the family and could not bear anyone to help her. If her sister did some dusting she would have to do it again. She was unable to let her children become independent; thus her eldest son at the age of 29 still slept in the parental bedroom. The daughter used to sleep in the parents' room until she was married. She developed hysterical symptoms which the physician diagnosed as the psychological outcome of this unhealthy situation. When she got married she brought her husband home to her family. Later they moved into a flat, but the girl seemed unable to manage away from her family and the mother suggested they should return to her, which they did. The DU son married a very possessive girl. After a short time he encountered severe difficulties

in his marital relationship and for a considerable time they were on the brink of separation. Throughout these difficulties the son kept in close touch with his family, and complained bitterly about his wife. The mother considered prospective daughters-in-law as rivals and enemies, accusing them, for instance, of 'taking liberties' in her house by sitting in the father's armchair. The strains brought about by the unhealthy closeness of this family seemed to find expression in much squabbling. The daughter-in-law called them a 'touchy family'. There was also much affection and helpfulness among the members of this family and the father's tolerant and easy-going way undoubtedly eased the strains caused by an affectionate but very possessive mother. Even so, none of the children were able to develop along healthy emotional lines, and their tight family ties created serious problems of social adjustment for each of them in turn.

In the Foster family (DU 22), the mother was the undisputed leader and the cohesive force in a big family group. The father exercised little, if any influence. They were a lively happy unit, while the mother was alive. Yet the mother's over-protectiveness had left its mark in the immature reactions of her sons. The eldest son, whom she adored, started living recklessly and extravagantly after joining the Forces, behaving in the outside world as though he was still his mother's spoilt darling who must have everything he wanted. At home he had 'been able to wheedle the last half-crown out of mother's pocket for dancing'. The second son also turned out to be a spendthrift. When Mrs Foster died suddenly, the family went to pieces. All the older children including the DU son scattered. The central uniting influence had gone and the home ceased to be the centre for social gatherings in the village as it had been in the mother's lifetime. The father became still more ineffective without her guiding hand. When the P.S.W. visited the simple Council house it had the appearance of a drab, lifeless place, probably very different from the home that had been enlivened by the very strong personality of this possessive, vigorous and hospitable woman.

The Fletchers (DU 21) were an interesting example of a family that presented a flawless outward front concealing many tensions. They were six in number. Mrs Fletcher and her younger sons ran a hardware shop and the family lived above it. The father was the

manager of a firm dealing in similar goods. The DU son, Ernest, was the only one who had different interests and pursued a technical training. They were a very close family and used to go on holiday together, taking a cottage in the Lake District. They 'loathed picnics' and had their meals in the secluded garden of their cottage. Ernest hardly ever went out in the evening and his brothers also spent most of their spare time at home. None of them, though well over 20, had any girl friends. The daughter, who had had many boy friends, contemptuously accused her brothers of being 'undersexed'. All the brothers were very dependent on their home and when Ernest was on leave from the Army the parents had to take him back in a taxi as he refused to return. His brothers were nominally in charge of the shop, but it was the mother who ran the business and gave all the orders when buying stock. Although she was determined to paint a happy picture of a united family, the submerged tensions gradually came to the surface. Ernest hardly communicated anything to his family; he resented his mother's probing and gossiping, and he had only agreed with the greatest reluctance to the P.S.W.'s contact with her. Although the mother and the younger brothers worked 'hand in glove', the mother admitted to becoming very irritated and exasperated at times. It gradually emerged that the father spent most of his evenings away helping a friend in his café. During the time of contact he gave up his managership and installed himself in a little shop selling hardware at the other end of the town. The mother had made it quite clear that she and her sons would not welcome any interference in the business from the father. It then became apparent that there were what the mother called 'first-class rows' between father and sons, which she tried to prevent by careful diplomacy. The quarrels between the brothers about the use of the bathroom, for example, were also settled by the mother and were in the nature of squabbles between small children. The daughter's marriage also reflected the family ethos in several ways. She too ran a shop with her husband and like her mother she gave little time to her home or to mothering. This 'business' family was in vivid contrast to the Brewer family in the control sample who were also shopkeepers, but who were involved in the shop as a family, each playing a different role in a truly cooperative undertaking. In the Fletcher family, the business

aspect of their lives presented a precarious balance of forces with deep emotional divisions and jealousies.

The tensions among the families in the control sample who were functioning fairly well were of diverse kinds. There were the tensions arising from the rejection of one member of the family who became the 'black sheep'; the difficulties that arose when the father and mother had somewhat different interests, but an attempt was made to bridge this chasm by a rational compromise; the disappointment of a father, thwarted in his own educational career, in his son who was throwing away his chances; the acting out to an excessive extent of neurotic tendencies. In only one or possibly two of the control families did the unhealthy closeness occur that in the DU sample hid so many submerged hostile tendencies. The stresses and tensions in the control families seemed more open, or perhaps the families were less ashamed of them, and for that reason they may have led to less strain and emotional conflict in the individual members. Two examples are presented to illustrate this point.

The Curtises (C 25) were apparently a happy family unit until the mother developed rheumatoid arthritis when her son was in his early teens and the daughter several years younger. During the first years of her illness the family rallied round in many different ways. The daughter used to help to dress her, the boy did shopping for her. The father has always been somewhat reluctant to take on a mothering role as he was suffering with heart trouble and was looking for support himself. As the years went by the son and daughter rebelled in various ways and the mother now felt that they were most unhelpful. The son, who married, lived in the ground-floor flat of the same house. He was said to show little sympathy for his mother and did not offer to bring in her shopping on Saturdays, when he and his wife did their own. He did not bring the milk up; on the contrary, he was cadging cigarettes from his mother. The daughter, who by this time was engaged to be married, also pursued her own interests and gave her mother a minimum of help. Although they were hard up, as the father missed much work on account of illness, his daughter expected a lavish wedding. At the time of contact, the P.S.W. felt very sorry for this lonely mother, who was becoming increasingly incapacitated, and the research team discussed why the family were so

unhelpful. But what was the meaning of this unhelpfulness? Was it perhaps a sign of psychological robustness and health that both the son and daughter refused to become preoccupied with the nursing of their mother? As these children had missed a good deal of fun and freedom in adolescence on account of their mother's illness, was it not understandable that they should feel resentful of her constant demands and her somewhat martyred attitude? Possibly the team had initially viewed the situation entirely through the eyes of the sick mother who felt deserted by her children and envious of their independence. When viewed in the context of the family situation, the attitudes displayed by the children possibly assume a different meaning. They may carry within them the potentials of better adjustment than attitudes in a family where children are outwardly helpful and inwardly hostile.

The Cox family (C 8) presented another interesting example of many outward tensions between members who were basically bound together by strong ties of affection. Mrs Cox was an obsessional woman who spent her life cleaning. She was married to an easy-going, untidy husband who strewed his ash all over the place and enjoyed sprawling in front of the fire at the week-end. He would have liked the mother to abandon all her housework then and share his pleasures with him. She, however, found it impossible to abandon her routine and 'hoovered around him.' She was fully aware of his wishes but could not help herself. Her admiration for her husband was intense, 'If there is anything wrong with my husband it's me. He is the best, most wonderful man I can think of in this world and we are as much in love as ever'. She would talk of his generosity and thoughtfulness, and of the many ways in which they expressed their affection for each other. He, though exasperated by her cleaning orgies and restlessness, said that he would not change her for anything in the world. The son was a studious undergraduate, something of an isolate, with many neurotic problems. He had had many battles with his mother from the time he was a toddler. He would argue with her and become exasperated by her 'ignorance'. He would insist on playing classical music, which she could not stand; he would refuse to do her shopping, yet after an argument he would pick up the shopping basket as though nothing had happened. Basically, there was a deep bond between them; he had similar obsessional tendencies

and in any family argument he found himself on her side. Despite his criticism he was well aware of the positive elements in his home life. Thus on one occasion he compared himself with fellow-students living in a hostel and remarked how profoundly grateful he was to 'be able to put my feet on the mantelpiece and have nice food and comfort'. His sister, a little younger, was a lively girl, who worked in a factory and had a steady boy friend. She was extravagant and stubborn and had more sustained rows with her mother than did her brother. Brother and sister too would argue and tease each other, but when it came to any issues with the parents they put up a united front. The mother had a marked tendency to identify herself with her children and derived much enjoyment through sharing their lives. She kept an open house, and the children's friends were entertained generously. The father, a steel-worker, who worked away from home most of the time, tended to be a little envious of his growing children and the fun they were having. There was rivalry between him and Cyril. If Cyril gave his mother a dozen tulips the father would appear a few days later with a bunch of tulips and a bunch of daffodils. He was also concerned over his daughter's late hours, although formerly he had encouraged his wife to give her more freedom. On the other hand, his generosity towards his children was remarkable. The arguments and disagreements that were fought out in this family were numerous. The mother got exasperated about the way the family expected to be waited on. Cyril got annoyed with his mother's many attempts at telling him what to do. The mother often spoilt the father's pleasure by insisting on doing her housework, and then felt very guilty about it. The daughter had fights with her mother over quite unimportant issues which resulted in sulks on both sides lasting several days during which they would not speak to each other. They all were aware of these tensions and had a good appreciation of what any member was feeling. They verbalized their feelings readily, were frankly critical of each other, and sparks flew easily. At the same time they all had a strong sense of humour which often helped them to regain a sense of proportion; they were all very generous and loved to give each other presents; and there was a strong feeling of solidarity between them. Major decisions were made by a 'family council'. They all had a considerable capacity for enjoying life and at

Christmas the father could not do enough to make it a happy time for everyone. Their feeling of being a united family despite their many dissensions was conveyed when the father decided not to buy individual presents one Christmas, but a radiogram for them all.

FAMILIES FUNCTIONING POORLY

In the third category of family functioning, there was far less evidence of affection, at times almost complete breakdown of communication, and very little evidence of sharing of common ideals. At the same time the insecurities and incompatibilities involved in such family situations induced much disturbance in the individual members so that it is possible to speak not only of poorly integrated but of sick families.

We saw an example of this in the Brown family where the mother suffered from sick headaches and Peter's young sister from asthma.

Another example of a poorly functioning family was the Gilberts (DU 3), already discussed in connection with the mother's lack of protection and the son's solitariness and emotional disturbance in childhood. The most striking feature was their disunity and the way in which each member fought for himself. Charles described his family as a 'selfish' one, and the mother gave many examples of how the sons would hardly lift a finger to help themselves, not even to the extent of taking their prepared dinners out of the oven, or offering to help her when she was chopping wood. Charles felt that his mother was a poor provider who did not devote enough time and care to the home and the welfare of the children. She felt handicapped by her bad eyesight and had never been able to satisfy her children or get active support from her husband. While she acknowledged his help in the house, she missed his companionship. She obtained her satisfaction outside the home in her work, in her relationships with her brothers and sisters, and in her friends whom she met at whist drives. The father was an unskilled labourer who suffered from 'black-outs' and was preoccupied with himself, his digestion, his rheumatism, and his bronchitis. He fulfilled some of the feminine functions in the home, making the beds on Sunday mornings, keeping the grate clean and washing up when his wife went out. He was very

conscientious but had little outgoing feeling. It all seemed to be concentrated on himself and his ailments. The eldest son in the family had always occupied a special place in the mother's heart. He was much more outgoing and cooperative than the other brothers and was generous towards his mother, being prepared to share anything he had. Charles's younger brother had always been the centre of conflict in the family as he presented severe behaviour problems from an early age. He was violently jealous of Charles and the parents felt that the jealousy had 'stayed in him'. He had always felt unwanted and thought that the world was against him. He was obstinate as a small child, had violent temper tantrums, and was very unkind to Charles. At school he was a great trial, unable to make friends and always fighting with other children. He was invalided from the Forces on psychiatric grounds as a 'backward psychopath'. He had various unsatisfactory associations with women, was unable to keep a job for any length of time, and had violent outbursts of temper. Later he was admitted for another period of mental hospital treatment and was diagnosed as an hysterical psychopath. The maternal grandmother often suggested that all he needed was understanding, but the mother in her own words was 'unable to give it'. Their temperaments clashed continuously and the father expressed concern lest the mother might do real harm to him if things went too far. His violent outbursts, irresponsible behaviour, and 'borrowing habits' made him unpopular with all members of the family, except the eldest son, who had quite a good relationship with him. More recently, however, this young man had married a nice stable girl who was able to give him the affection he appears to have craved all his life. He had settled down to regular work and started to lead a more stable life. Charles virtually withdrew from the family circle, and hardly ever communicated anything of importance to his relatives. He was sharply aware of the deficiencies of his home and his critical attitude was felt acutely by his mother. There was a complete lack of give and take in their relationship. Charles was always expecting things and not getting them, and feeling bitter and frustrated about it. The mother felt hurt by his inability to tell her anything, and by his lack of appreciation of anything she did. Charles's relationship to his brothers was also of a very tenuous kind. He was never able to get on with his younger brother, who

had resented him so bitterly, nor had he any warm relationship with his older brother. His youngest sister seemed to follow very closely in his footsteps; she was dissatisfied, critical, and demanding. Charles on the other hand felt that this sister was 'spoilt' and that she had more material advantages than he had had, as the family was much better off during her childhood. He was also envious of his sister's better educational chances and her superior ability. He was one of the DU boys who had an urge to exercise authority and control over his younger sister, not only, it seemed, because he needed to assert himself over her, but possibly also in order to give her the guidance he had never received himself. Charles carried over to the outside world the discordant relationships in the family. In his interviews he often described his office and his football club as disunited, squabbling communities in which people talked behind each other's backs and in which there was no common loyalty. The difficulties of communication were increased in this family because Charles and the youngest sister had higher intelligence and greater social ambitions than their simple working-class parents.

The Baxters (DU 20) were an example of family disunity in which the children 'gang up' with the mother against the father. The father, a skilled worker of Hungarian descent, had always been extremely jealous of his wife. He was a man who wanted his wife to mother him, a role which she resented. They had six children, all sons, and the father became increasingly jealous of the boys and accused the mother of preferring the children to him. He used to promise treats to the children and then hardly ever kept his promises to take them out or to buy them toys, so that it was the mother who took them on little outings. The mother's critical attitude towards the father, which she voiced freely, was taken over by her sons, and Paul, the eldest, was ready to defend her when the father started quarrelling. He complained to the psychiatrist that there was 'no peace' in the family and that everybody was 'in a funny mood at home'. When the sons were growing up the father appeared to compete with them. For example Paul became very interested in stamp-collecting, so the father started a bigger collection. The other children, who were still of school age at this time, looked to Paul rather than to their father as their hero. The mother partly solved her problems by going out

to work in the evenings, which meant that she spent very little time with the father. In this family, too, Paul was by no means the only person who had become sick. Several of his brothers showed signs of disturbance and one of them, a very solitary and withdrawn child, had attended a child guidance clinic.

It seems that the basic problem from which most others stemmed in these disturbed DU families was the incompatibility of the parents, that is to say their inability to play the roles demanded by their partner, which eventually led to severe estrangement. One of the causes of this incompatibility was the problem discussed earlier: the refusal of the wives to 'mother' their husbands, and their highly ambivalent attitudes to their children that resulted from their own frustration. Two solutions appear to be possible in families where serious estrangement occurs between the parents. Either the rest of the family take sides and the group is thus split into two camps, as were the Baxters, or the children emulate their parents' example and go their own ways in an attempt to be self-sufficient, since no complementary roles can be found within the family group—like the Gilberts. It is understandable that this basic insecurity and the lack of acceptable models for identification lead to much stress and emotional illness in these families. Thus in 5 of the 6 DU families in this category the siblings were found to be emotionally disturbed.

Four control families were rated as poorly functioning. The causes for the disruption were more obscure and did not seem to be directly related to the marital relationships. In two families the fathers' excessive drinking led to much stress and conflict. In both of them the mothers were very fond of their husbands and, although there were many quarrels and even short periods of separation, they stood by their husbands through many crises and eventually both marriages became more stable and satisfying. In both families the effect of the insecurities caused by the father's conduct has been harmful to the children, who have shown a good deal of instability. The other two families in which disunity and emotional instability were much in evidence present many puzzling features.

The Freeman family (C 26) consisted of the father, a steady goods guard on the railway, who had been in his job for over twenty years, the mother, a somewhat depressed and rather

shifty-looking woman, and six children. As far as could be ascertained the marital relationship was happy. The father provided for the family well, the mother had always gone out to work, and the children were minded by the maternal grandmother when they were small. Within the limits of her moderate intelligence and of her curious emotional flatness, this mother seemed to have done her best. Yet there was much unrest and instability in the family. The control subject, Leonard, was a very mischievous boy and a persistent truant, who was eventually sent to an approved school. He committed further delinquencies in late adolescence and was sent to prison. A younger sister was a border-line defective. She stayed out late at night at the age of 15 and finally absconded altogether after her father had issued stern warnings to her. She was suffering from V.D. and leading a promiscuous life when last heard of. Another brother, recently discharged from the Forces, was sitting about at home, refusing to find himself a job. On the other hand, at the time of contact with the Unit, Leonard was making a fairly good adjustment. He was in steady employment and he drew a cosy picture of the relationships at home saying that their only worry was the wayward sister. He was drinking rather heavily at the week-ends. The eldest daughter was a conscientious, sensible girl who got married during the time the team was in touch with the family, and two younger siblings, still at school, seemed to present no problems. When the P.S.W. visited the home she was always made welcome and although the house was a tumbledown cottage in one of the poorest streets in the borough, the living-room-kitchen was always fairly tidy and comfortable. The research team has never been able to answer the question as to why three members of this family should have become so seriously unstable when they seemed to have received a reasonable amount of care and affection in a stable family setting. At times the P.S.W. wondered whether the mother was hiding some secrets—she was not completely truthful. On the other hand she appealed to the P.S.W. when she was in distress over her wayward daughter, being quite frank about the nature of her problems. The family doctor was equally puzzled by this family, and unable to put his finger on the cause of disruption.

The Cooper family (c 5) presented a different picture. The father was an artistic, highly strung man who on the first visit took

up a very aggressive and negative attitude to the P.S.W. He had taken over a little greengrocer's shop from his father and earned his living in this way since he was a boy. The family lived in rather dark and uncomfortable premises connected with the shop. The mother was a somewhat untidy person, and an ineffective housekeeper who made many attempts to improve the living-room, which however always looked uninviting. She suffered from severe phobias and was unable to go out by herself. The relationship between her and the father was a very close and affectionate one. They went out together almost every night, and he was said to be very jealous of her. Their daughter and two sons appeared to have spent a happy childhood. The control subject, Horace, had always been intensely jealous of his younger brother whom he felt to be much preferred by his mother. He watched anxiously to see whether this brother had more than he had, comparing their rations and even weighing his butter. He became disturbed while on National Service and since his release had been unable to keep any job for longer than a few weeks. He had many problems. He was preoccupied with his boils and with his body generally, taking special precautions against dry skin and wrinkles and he had an array of medicine bottles. He seemed obsessed with his sexual life and sexual fantasies and consumed by jealousy of his girl friend. He felt very aggressive towards his mother and complained bitterly about her inadequate housekeeping. He quarrelled with his father about what he called his 'meanness' although the father had often kept him when out of work. His brother, who was described as more stable and friendly but less intelligent, created fewer difficulties in the family circle by his behaviour and attitudes, but he was equally unable to keep any job for longer than a few weeks. Thus much unhappiness had overtaken the Cooper family, which was rent by quarrels and dissatisfactions, the parents complaining about the boys and the boys about the parents. It is possible that the control subject, who was seriously unstable, and was considered to be an hysterical psychopath, was the actual cause of disruption. On the other hand, it is difficult to understand why both these boys should have become failures after an apparently happy childhood. Although the mother was ineffective, neurotic, and untidy, she appeared to be capable of affection for her husband and children and of considerable

insight into the nature of the family relationships. The father though 'edgy' and highly strung, had shared a good deal with his growing children, and had only very recently developed a discouraged and negative attitude towards them. The parents' defects thus did not seem serious enough to account for the family's disintegration. Yet, when in contact with this family one was uneasily aware that deeply disruptive but elusive forces were at work.

DISRUPTED FAMILIES

The families in which disruptions had occurred through parental separations have already been mentioned in the chapter on marriage, and their incidence was shown to be similar in the two samples. It may however be mentioned that three marriages in the DU sample as against one in the control sample actually ended in divorce. This of course may be no more than a chance result, but it may reflect the greater 'tidiness' of the DU families. The families in the control sample may have been more ready to drift along with unofficial separations without having the urge to put a final seal on the break. So far, however, little consideration has been given to the effects these separations had on the family as a whole. One general point can be made from the study of these nine disrupted families in both samples. The consequences for the family and the mental health of their members seemed most serious when two incompatible partners with utterly opposed values stayed together, because this state of affairs did not allow the children to take over a consistent set of values or attitudes. There was a striking illustration of this in one DU family where such gross incompatibility of attitudes and values occurred in the parents that all their children became involved in serious conflicts and stressful life situations.

This Jewish family (Harris, DU 13) of German origin consisted of the parents and six children. They came to this country in the nineteen-twenties. The father was a master at a boarding school and lost many jobs through his unstable behaviour, until finally he had to give up this calling. He was a difficult man to live with, and had periods when he would shut himself off from his wife. Sexually he was both perverse and promiscuous. He was fond of gambling and a life of pleasure. In many ways he was reported to

have been an attractive man who could be charming and plausible. His irresponsible and highly sensual behaviour presented one kind of model for his growing family, which was in great contrast to the ideals the mother tried to foster in her children. She was an extremely conscientious woman and a perfectionist with high ideals and intellectual ambitions for her children. Spiritual values and intellectual achievement meant a great deal to her. She was constantly encouraging her children to do the things that were most difficult for them and she was gratified if, for instance, they gave up their pocket money to poorer children in the class. Her moral pressure and perfectionism undoubtedly made life hard for husband and children alike. The parents' instability and conflicting ideals created insuperable difficulties for the surviving children, who were all severely emotionally disturbed. The eldest son married a non-Jewish girl, a somewhat rebellious act in an orthodox family. She was a very neurotic and sadistic woman, to whom he submitted, being a gentle and generous person. His wife seemed to be an exaggerated version of his subtly sadistic and driving mother. He tried to solve some of his marital problems by having a mistress, thus repeating his father's behaviour. In his job, as a solicitor he committed various indiscretions which brought him into conflict with the law. Part of this trouble appears to have arisen from an inability to deal wisely and rationally with financial matters, which was one of his father's problems, and from a desire to take on far more work than he could possibly carry out, which was a tendency of his mother's. The next sibling also married a non-Jew, and she appeared to be happily married. She got into serious debts and in order to pay them back took money from her employer. Again this irresponsibility, which seemed a repetition of the father's behaviour, coincided with the desire to be generous to her husband and family. All this woman's financial difficulties arose because she bought big presents for her family. This her mother stressed particularly as an extenuating circumstance. The DU SON was torn by many emotional conflicts. He was worried about sexual problems and he too had the family failing of behaving irresponsibly over money and spending more than he had. At school it was noticed that he never achieved much because he was always inclined to take on more than he could possibly carry out, which again was

reminiscent of his mother's pressures. The youngest child, a boy of 16, remained the only one at home. He was thus continually exposed to the mother's neurotic drives and ambitious strivings. As the parents had separated when he was small, he did not have to cope with his father's problems to the same extent as his siblings. Although there was much affection between the mother and this boy, they had almost daily scenes in which Reuben tried to rebel against the standards his mother wished to enforce on him in relation to his clothes, his friendships, and his methods of study. He had many problems about his relations with other boys and girls. He developed fainting attacks and frightening nightmares. Despite the serious disturbances in this family there was still a cohesive bond of affection between them. When the two eldest siblings got into their financial difficulties, the family rallied round, pawning anything they could in an effort to help. Although the father had never done much to help his children, the two eldest siblings kept in touch with him and preserved some affection for him. Similarly all the children were very devoted to their mother, who had made many sacrifices in order to bring them up and to help them to the best of her ability. However, the cohesive bond of affection that to some extent held this family together did not help the children in solving the insuperable problems created by the deep division between the parents.

In reviewing the functioning of the families as groups, it will be seen again how in the D U sample the mothers' dominance, possessiveness, efficiency, and obsessional idealism, which partially contributed to the cohesion of the family, could create serious problems of emotional and social adjustment among all the members of the family. Characteristically in the D U sample the family was a closely knit unit in which the expression of positive feelings and still more of negative attitudes was restrained. Their ideals of respectability, the stress laid on maintaining high standards of behaviour, and the concern with 'what the neighbours think' were also prominent. By contrast, in the control sample feelings were expressed and discussed with comparative freedom. Some of the diverse ways in which families can function well or disintegrate also became apparent. More evidence was adduced that neurosis or mental illness *per se* need not be a disruptive force as long as members of the family could play roles which helped to

fulfil their own needs as well as the needs of other members, and as long as there was some capacity to tolerate individual differences. When emotional instability was combined with incompatibility between the parents and their conflicting values, then the family cohesion and the mental health of its members were seriously threatened. Finally, there were some families whose disunity could not be satisfactorily explained in terms of current theories about parent-child relationships and the influence of these on adjustment in later life.

CHAPTER X

Summary and Conclusions

In the foregoing chapters a comparison has been made between the family backgrounds of 32 young men suffering from duodenal ulcer and those of 32 young men who did not suffer from ulcer or any form of chronic dyspepsia. The ulcer patients were between the ages of 16 and 25, and they had all attended certain hospitals during a single calendar year. The controls were drawn at random (except only that they were matched for age) from the register of a local general practitioner.

THE FINDINGS

General Background

The two samples of men were similar as regards both their occupations and the occupations of their fathers. Their intelligence and the type of education they had received were very similar. Their marital status was almost identical. Few differences emerged in relation to size of natal family and the ordinal position of the young men in the family. The incidence of 'broken' homes in both samples was virtually the same.

The Mothers

The outstanding characteristics of the D U mothers were their striving and dominance, their obsessional traits; and their tendency to develop psychosomatic symptoms. Two-thirds of the mothers in the D U sample were dominant and controlling personalities who made the major decisions in their families, and were the leaders and the sources of authority in the home. One-third of the mothers in the control sample had similar characteristics. (The ratings on these and other attitudes were based on

defined criteria.) Apart from the demands of external circumstances, the dominance of these women appeared to fulfil different kinds of needs: the needs of conscience; the desire to emulate men; the need to 'mother' people. Almost two-thirds of the mothers in the DU sample showed marked obsessional tendencies, as against one-quarter in the control sample. The mothers were often very conscientious women with a high sense of duty, who were exceedingly houseproud and devoted to efficient routine. A far greater number than in the control sample developed psychosomatic symptoms (12 to 1). No differences were found in the frequency of neurotic traits, which were numerous in both samples. Superficially the mothers in the DU sample gave the impression of good adjustment. They were hard-working, efficient, vigorous, cheerful, and outgoing personalities who did not give in easily in face of difficulties. The mothers in the control sample seemed to have more diverse personalities.

The majority of the mothers in the DU sample exhibited much loving and protective care, and great conscientiousness in the upbringing of their children. They were what are commonly termed 'good' mothers. However, they often showed in extreme form one or more of three maternal attitudes: a tendency to *protect* their children excessively from real or imaginary external dangers; a tendency to *restrict* and control their children's activities and to mould them to a preconceived pattern, and a tendency to *over-indulge* their children, often expressed in a compulsion to give, irrespective of the child's needs. Three-quarters of the mothers in the DU sample compared with one-third in the control sample revealed these attitudes, either singly or in combination. The mothers in the control sample were on the whole more easy-going and flexible in their responses to their children. They had less of an 'either-or' attitude. They were able to employ their energies in more diverse ways, and perhaps for this reason they had a less intense and possessive attitude towards their children: thus, more of them went out to work during the first ten years of their sons' lives and yet seemed able to combine such work with what would usually be considered to be adequate maternal care.

At the other extreme there was a smaller group of DU mothers who showed a lack of indulgence (7) and of protectiveness (6) in particular. There were only two such mothers in each of these

categories in the control sample. While 'over-mothering' seems to have been the lot of many boys who subsequently develop ulcer, further careful studies might show 'under-mothering' to be a significant factor also. This is not as contradictory an hypothesis as may appear at first sight because it was seen that 'over-mothering' often contained some elements of unconscious rejection and constituted an attempt on the part of the mother to make reparation for this.

The Fathers

The fathers in the DU sample were studied less intensively than the mothers. They showed a characteristic steadiness and unassertiveness both at work and at home. Twenty remained with the same firm or service for fifteen years or more. Although some of them obtained promotion, it was generally within certain limits, and with a tendency to avoid the burden of executive responsibility. A smaller but still considerable proportion of the fathers in the control sample (13) showed similar settledness in their work. At home, the behaviour of the fathers in the DU sample was also characterized by a certain quiet steadiness and passivity. Many of them apparently acquiesced in the leadership of their wives. At the same time they were often constructive men, interested in their homes and involved in pastimes and hobbies that constituted a separate sphere of activities away from their wives.

A striking feature was the preponderance of 'stomach' disorders among the fathers. Twelve in the DU sample, as against five in the control sample, suffered, or had suffered, from DU or chronic dyspepsia. The prevalence of neurotic traits appeared to be about equal in the two samples, so far as could be judged. In both samples symptoms of depression, anxiety, and hypochondriasis were much in evidence.

In their relationships with their sons, the majority of fathers in both samples were tolerant and easy-going. The relationship was often described as 'pally' or 'brotherly', and the fathers who were stern and feared authority-figures were very much in a minority. A difference between the two samples was discernible in the degree of closeness of the relationship. The fathers in the DU sample seemed to have a more distant relationship with their sons than the

fathers of the controls, who shared more interests and activities with their growing boys. On the other hand, there was a suggestion that the fathers in the DU sample showed more interest in their children as babies than did the fathers in the control sample.

The Boys

The outstanding difference in the reports of the childhood of the DU and control samples, was the marked lack of overt aggression in the DU boys. Two-thirds of them were described as quiet and well behaved. In the control sample just under one-third were said to have had similar characteristics. While half the boys in the control sample were described as 'ordinarily aggressive and mischievous, only one-sixth of the DU children were reported to be so. The same small number of boys in both samples were described as markedly mischievous and aggressive. It was thought that this 'good' behaviour was related to the tendency of the conscientious, careful mothers and the steady quiet fathers, in the DU families particularly, to discourage the expression of aggression. It may also be that the mothers were on the whole so 'good' and powerful that it was difficult for the boys to rebel.

There was a closer tie between the boys and their mothers in the DU sample than in the control sample. The information suggests that the dominant and mainly indulgent-protective mothers evoked a close, overtly dependent relationship. On the other hand, the dominant and mainly restrictive-protective mothers, while also keeping their children closely tied to them, tended to arouse concealed resentment in the children who made some attempts to free themselves from their mothers' control. It was thought possible that these two maternal attitudes, and the corresponding child responses, may be linked to the two contrasting types of adult DU personality so often described: the overtly dependent; and the overtly independent, who denies his underlying dependent needs. Although looser bonds were found between the majority of sons and mothers in the control sample, over one-third also had close ties with their mothers, which at times were of a very intense nature.

The boys' reactions to wartime evacuation did not appear to differ in the two samples; but an interesting difference, despite quite similar external circumstances, was that seven families

evacuated together in the DU sample, whereas only two families did so in the control sample. This may be another illustration of the DU mothers' greater need to hold on to their children.

Friendliness between sons and fathers prevailed in both samples, and adolescent clashes were rare. A more wholehearted acceptance by the lad of the father's values and way of life was found in the control sample. In the patients this definite and conscious identification only occurred in a minority of cases where the father was particularly successful in his job.

The only remarkable feature noticed in the boys' relationship with their siblings was the attempt on the part of the boys in the DU sample to vent aggression on their older or younger siblings and to dominate them in a 'moralizing' way. In the controls this behaviour was not reported, and sibling rivalry was more usually expressed in open jealousy and envy.

No striking differences emerged regarding relationships with other children outside the family. There were a few more solitary boys in the DU sample (7 to 3), a consequence perhaps of their more protective environment. In evaluating the somewhat surprising finding that the quiet, well-behaved DU sons were reported to have been almost as 'good mixers' as the children in the control sample, the practice of encouraging relationships with children outside the small family circle has to be taken into consideration, together with the emphasis currently laid on popularity.

Likewise no differences were found between the two samples in their achievement at school. The same proportion in both won scholarships to grammar and technical schools. There is no indication that the children in the DU sample worked harder, made greater use of their innate abilities, or achieved more in their school careers than the children in the control sample, although their parents were on the whole more ambitious. In both samples an appreciable percentage with I.Q.s of 112 or over on the Wechsler test did not win places to either grammar or technical schools.

No differences were found in the physical health of the two samples of children, both reporting good health on the whole. Regarding their mental health, very few differences in overt symptoms were reported. Six boys in the DU sample and five in the control sample seemed to have been seriously disturbed in childhood. Neurotic traits were similarly distributed except in

two items, temper tantrums and nail-biting. While some children in the control sample turned their aggression outwards in the form of temper tantrums, a number of DU boys indulged in nail-biting—turning their aggression on to themselves.

The Families

Since the stability and satisfaction found in the marital relationship were considered to be of central importance in the life of the family, an attempt was made to compare the marriages of the parents in the two samples. For this purpose five criteria were stated on the assumption that a successful marriage is a dynamic process in which the needs and expectations of the partners can be fulfilled; rather than any fixed state of ideal happiness. These criteria were—(i) the degree and ease of communication between the partners; (ii) the preponderance of positive over negative feelings; (iii) the ability to assume roles that fulfil each other's basic needs; (iv) the ability and preparedness of the partners to work through difficulties; (v) the recognition and toleration of individual differences. The marriages were then grouped in three categories: first, *the harmonious marriages*, in which there was evidence of good communication, predominance of affection, complementariness of roles, 'working through' of tensions when they arose, and tolerance of each other's differences; second, *the outwardly stable marriages* in which there was much hostility towards, and criticism of, the spouse, where roles often clashed, and did not meet the needs of both partners, and where tensions were not worked through, but were at best 'put up with'; third, *the broken marriages*, in which friction and incompatibility were so serious that they had led to, or were likely to lead to, separation or divorce.

The distribution of the marriages among these three categories was very similar in the two samples, although there were slightly more 'harmonious' marriages in the control (20) than in the DU sample (16). However, a characteristic balance of forces was evident in many of the marital relationships in the DU sample. As might be expected in view of the personalities commonly found in the parents, the cohesiveness and equilibrium of the marriages often depended upon acceptance by the somewhat passive husbands of their wives' dominance. The latter frequently seemed to

be disappointed in their husbands' achievements. The 'harmonious' marriages in the control sample on the other hand, revealed some of the different ways in which a marriage can fulfil important emotional needs in both partners. These relationships included: a bold redistribution of customary roles; mutual fulfilment of needs arising from unresolved childhood problems which were adapted in various ways to the realities of married life; the creative conflicts between opposed personalities and their continual re-adaptation to one another; and the ability of two people with diverse gifts and interests to fit in with one another and make positive use of their differences.

In the 'outwardly stable' DU marriages it was usually the wife who 'kept things going'. The dissatisfaction of the efficient and controlling wives *vis-à-vis* their husbands was often an outstanding feature of the marriage. In both samples the 'outwardly stable' marriages contained certain common unresolved problems: the persistence of severe unresolved childhood conflicts, the disparity between the partners in intelligence and values, and the choice of an unsuitable partner as a means of escape from difficult situations at home or work. In the 'harmonious' and 'outwardly stable' marriages alike, stresses and strains were frequently offset, although to differing degrees, by emotional satisfactions.

The nature of the breakdown in the broken marriages (DU 5, control 4) also seemed similar. The incompatibility of the partners' sexual, social, and emotional needs often coupled with serious instability—and perhaps underlying them, the frustrated search for a parent substitute in the spouse—seemed to have brought about the breakdown. Since the marital relationship acts as the central one on which most of the family relations depend, the families in which the marriages were broken were by definition disrupted.

However, there is by no means a perfect correlation between stability of marriage and the cohesion of the family as a whole. While most harmonious marriages were found to give rise to well-functioning families, in the DU sample in particular the characteristic equilibrium achieved in the marriages combined with the closeness of the mother-son relationship was not always conducive to the harmonious functioning of the whole family group. Thus only 6 of the 16 DU families in which the marriages were

rated as 'harmonious' were considered to be functioning well as against 12 out of the 20 in the control sample. Such families engendered ties of affection and cooperative attitudes between the members, particularly in times of crises. Basic values were shared though there was tolerance for individual growth and ability to adapt to change. It is worth noting that none of these well-functioning DU families was particularly dominated by the mothers. Although these families conveyed warmth and affection, the expression of positive feelings and particularly of negative attitudes was somewhat restrained, and they laid great stress on respectability and the maintenance of high standards of behaviour. The control families who functioned well displayed more spontaneity and discussed their feelings with more freedom and less conventionality.

Most of the DU families in which the marriages of the parents were harmonious or outwardly stable were considered to be functioning only fairly well or even poorly, that is to say they contained hostilities and tensions that were never quite resolved but either smouldered beneath an outwardly cooperative surface or resulted in each member going his own way. The strains in these DU families seemed to emanate from the difficulties that the restricting or possessive mother created for them. The flexibility characteristic of the families that functioned well (whether in the DU or control sample) was absent. Instead there was a certain rigidity that did not make for the solution of problems. The closeness and apparent cohesiveness of such families often had a restricting influence even to the point of strangling the emotional growth of their members, whereas the truly cohesive families had sufficient security to encourage individual growth. Thus examples were seen of DU families in which all the children encountered serious difficulties in the process of growing up emotionally, and in which the close involvement of the members with each other produced many hidden tensions. On the other hand the tensions among the control families which were not functioning so well were much more overt and so could be grappled with more easily.

The impression was gained that in the DU sample the marital adjustment was often maintained at the expense of the children; that is to say, the mothers would attempt to satisfy through their

sons some of the needs that could be more appropriately fulfilled in the marital relationship or through other activities such as work, while the fathers for their part did not help the sons to stand up to the mothers' pressure. Where the marital relationship was precarious, the mother's pressure on the son became greater still and the dissatisfactions in the family increased accordingly.

In the control families, on the other hand, if a marriage was not all it might have been, the greater ability of the mothers to spread their activities over a wider sphere and the more positive part the fathers played in their sons' lives provided alternative roles and satisfactions that helped the family to function as a fairly effective group.

The number of families in which there was much disunity among the members and where the home was 'a place where you hang up your hat' was almost equal in both samples. But whereas the disparity between the parents and the highly ambivalent attitudes of the mothers towards the children seemed to provide some explanation of the disruption in the DU sample, the causes of disruption seemed much more obscure in the control sample.

Family life in both samples showed once more that neurosis and mental illness *per se* need not produce disruption as long as members of the family can play roles that help to fulfil their own needs as well as the needs of others in the family and as long as there is some tolerance of individual differences. When emotional instability was combined with incompatibility of the parents and with conflicting values, then the family cohesion and the mental health of the members were seriously threatened.

Thus the tentative hypothesis is offered that the emergence of DU in young men is associated with a predominantly stable family background. Dyspepsia and other psychosomatic symptoms are prevalent in the families. The bonds between the members of such families are tight and the mother plays a prominent role, not only as home-maker but also as organizer and authority figure, and thus is in danger of binding her son too closely to her, while the father is a kind of older brother who rarely becomes an admired model. It is also suggested that the emergence of DU is associated with the careful and protective mothering and training the son has received, which appear to produce a 'good child' who finds it

difficult to express aggression. In this way the conflict between dependence on a powerful mother and a protective home and a desire to free himself from the mother's control in order to meet the demands of adult life may be a basic one in the duodenal ulcer patient. This is an hypothesis that has already been put forward by Alexander and others, although on rather a different kind of evidence. It is suggested that the full brunt of this conflict and its associated problems may be felt by the boy only when he attempts to leave the shelter of his carefully regulated home.

VALIDITY OF THE FINDINGS

The validity of the findings may be questioned for several reasons. It may, for instance, be suggested that the investigator's knowledge as to which families included DU patients and which did not biased the approach. However, a 'blind' clinical investigation is clearly impracticable in this field. If the parents were asked to conceal the fact of their son's illness for the sake of an impartial investigation, it would probably lead to great distortions of fact and attitude. It seems that the only hope of guarding against bias is to be constantly aware of it and to employ certain precautions. For example, it is helpful to record the interviews carefully and accurately as soon as possible after they have taken place, to scrutinize the case material frequently for likely gaps in information, and to use as far as practicable 'operational' criteria in describing and interpreting behaviour. The finding that just as many mothers had neurotic traits in the control sample as in the DU sample may be one indication of the investigator's attempts at unbiased interviewing, recording, and interpretation, since expectations based on clinical experience might have inclined the investigator to see the DU mothers as more neurotic.

Another objection that can be raised is that detailed scrutiny will always lead to the discovery of differences between two groups. I am also aware that the differences found between the two samples are not necessarily related to the emergence of duodenal ulcer in one of the samples. Some of the differences may be related to more general factors of health or illness, for instance 'neuroticism'. Whether any are specifically related to duodenal ulcer can only be settled by further investigation. In this connection it is of

interest that Bennett in her study of delinquent and neurotic children found that the family background of neurotic children was very similar to that of the ulcer patients described here (Bennett, 1950). She found that restrictiveness in the mothers, good behaviour and lack of aggression in the children, and a relatively stable external family background were significantly more common in the neurotic group. Features that were significantly more frequent in the delinquent group included 'broken' homes, anti-social behaviour on the part of the parents, inconsistent discipline, interruption of relationships between children and parents, and aggressive and defiant behaviour in the children.

Again, many of the differences found in the present study could have occurred by chance. Numbers were small, variables qualitative and highly interrelated, and only a few comparisons out of the many possible were selected. For these reasons significance tests were not used, since it was felt that they might give a false air of proof or disproof. Instead I prefer at this stage to look upon the findings as suggestive hypotheses to be tested further by more rigorous procedures. However, the apparent consistency of the findings in psychological terms, and the ways in which they form patterns, suggest that they are characteristic of two groups of families that differ psychologically and that they have not arisen by chance.

Above all, it will be asked: How are these differences in family background related to differences in the adult personalities of these young men? This question cannot be answered here but is dealt with to a certain extent in Appendix I, which discusses the results of the psychological tests.

POSSIBLE IMPLICATIONS OF THE FINDINGS

Almost all the findings represent trends that, though more marked in the DU sample, are also discernible in the control sample. For example, maternal dominance, the father's passivity, the boy's lack of aggression, the close tie between mother and child, and the distant relationship between father and son were found in about two-thirds of the DU families, but also in about one-third of the control families. Thus the characteristics found in the DU sample seem to be exaggerations of tendencies present in the sample of

controls. If one considers how common duodenal ulcer and neurosis are in our society, this type of distribution becomes intelligible. Indeed it may well be that the typical patterns found in the DU sample represent particularly conscientious responses to the current demands of society. The DU mother has responded eagerly to the demands for higher standards of child care. The father has responded to the trend towards security by conscientious toiling and avoiding risks. Both have striven to make a civilized gentleman of their son by discouraging undue expression of instinctual drives. Only more extensive studies of ordinary families and of families with certain types of illness and maladjustment can throw further light on the specificity of the factors found, and establish more adequate knowledge of current norms.

Perhaps the interest of this comparative study lies less in the differences emerging between the disease and control groups and the possible contribution it can make to understanding the pathology of duodenal ulcer, than in the emergence of similar trends in both samples pointing towards common changes in roles and attitudes. Among the most important are the uncertainties and conflicts resulting from the changing roles of men and women. The increasing authority role of mothers may lead to considerable problems of identification in their growing sons. The incompatibility of this tie to the mother with the demands the outside world is going to make on the young man is likely to lead to serious conflict. The emergence of psychosomatic illness may be one sign of this conflict.

This study also raises the question of how women can best combine their mother-wife roles with their newer social and occupational roles outside the home. The growing concern with the child's emotional needs and the stress on the importance of a continuous and secure mother-child relationship during the first years of life are leading some enthusiasts to advocate the wholehearted return of married women to their homes while their children grow up. However, in this limited investigation the impression was gained that the driving dominance of the DU mothers and their attempts to realize some of their frustrated ambitions through their children might have been less if they had had other outlets for their creative energies and social needs outside the home. Many mothers in the control sample seemed able

to combine their maternal housewifely roles quite successfully with work outside the home, which satisfied not merely economic but a variety of social needs. Thus the dogmatic and one-sided interpretation of the new insights into the fundamental importance of the mother-child relationship may prove just as much of a danger to healthy development as does neglect.

Similarly this study revealed much uncertainty about the father's roles in the home. There is a growing tendency for fathers to be interested in their children when small and to help their wives in household tasks and child care, and this development enhances the cooperative spirit and flexibility of the family unit. However, this study leads one to ask whether fathers are becoming less interested in sharing sports, hobbies, and other 'masculine' pursuits with their growing boys. What is the 'role-model' the modern working-class or middle-class father provides for his son? Are the anxieties over dependency that the fathers revealed related to important cultural changes such as the reluctance of wives to adopt a maternal role and the decrease of the fathers' authority in the home, which are depriving men of opportunities for discharging both dependent and aggressive impulses? Only more intensive and extensive further investigations can answer such questions. What are the psychological and social implications of the fathers' predominant striving for security? Will their sons be equally cautious and conscientious? Or will the relative economic security of their childhood and adolescence enable them to be more adventurous than their fathers?

What are the implications of the findings that in both samples a considerable proportion of the boys, though above average in intelligence and intellectually capable of obtaining scholarships to grammar and technical schools, did not in fact secure them? Although the dislocation of educational services during the war may have played a part, pre-war studies showed that a considerable potential of intellectual ability went unused (Gray and Moshinsky, 1938).

What is the meaning of the comparatively high proportion of failure in the marriages? As other writers have pointed out, this failure rate may indicate that people now demand higher standards of satisfaction than they did in the past, and that more and earlier marriages may draw a wider range of personalities into the

orbit of marriage and thus increase the risk of failure (Titmuss, 1954). There are also indications of a growing diversity in the social origins of husbands and wives (Berant, 1954), and this may further contribute to the risk of failure because of the spouses' possible differences in values and accustomed ways of life. It is also possible that an intensive study in which people are encouraged to talk freely to an outsider uncovers more stress than acquaintance in everyday life with the same families would reveal. Although this study disclosed a higher proportion of failures than the statistics of divorce alone show, it also indicated the enormous range of possible satisfactions that two people can derive from being together and that are often hidden behind external stresses and hardships. It would seem that if we learned to look at marriage from the point of view of fulfilment of needs, however diverse, and the complementary nature of roles, however unconventional, we might arrive at a more dynamic and rewarding understanding of the marital relationship. It would then be possible to dispense with many of today's stereotyped and unrealistic notions of what constitutes 'marital happiness'; for marital happiness seemed to mean totally different things to different people with different needs and expectations at different periods of their lives.

This study has also thrown some light on the cohesiveness of family life. The very cohesiveness of the DU families often had its roots in maternal possessiveness and the resulting tightness of relationships. It could obstruct individual growth, and threatened to keep the offspring immature 'sons and daughters' throughout their lives. This problem, so frequently met with in the DU families, seemed to highlight certain contradictions in the changing patterns of family life. Outwardly, modern parents are more democratic and less authoritarian than previous generations, and children have more freedom, and are treated as persons in their own right. Outwardly, independence is encouraged; urban children have to negotiate complex traffic from an early age. They are encouraged to associate with their peers in all kinds of formal and informal groups, and sometimes start travelling abroad when still at school. Yet, at the same time, because of the smallness of families, the growing interest in and anxiety over the child's emotional development, the high standards of child care demanded in

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nutrition and in many other respects, the emotional bonds between children and parents may become tighter, more exclusive, and more permanent than the bonds that were created in previous generations by external coercion and control. This involvement between parents and children is enhanced by the continuing tendency in industrial societies for families to be stripped of many of their former functions, economic, social, and even domestic. Thus, far from pointing towards a disintegration of the family and a loosening of bonds, this study suggests that there is a possible tightening of emotional bonds between parents and children in the urban families of today.

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APPENDIX I

A Comparison by Means of Psychological Tests

Young Men with Duodenal Ulcer and Controls

VICTOR B. FANTER¹

Most of the young men whose families have been described by Miss Goldberg attended the Unit for two psychological testing sessions each lasting about two hours. The psychological test results showed that the group of young men with duodenal ulcers undoubtedly differed from the control group, although it was remarkably similar in most respects. A study of such differences as were observed suggests that they are consistent with some of Miss Goldberg's conclusions which are based mainly on interviews with the mothers of the young men, and, to a lesser extent, on talks with their fathers.

Readers of her book will therefore probably be interested in the conclusions reached on the basis of psychological tests, but these cannot be evaluated without a description of the ways in which they have been arrived at. Hence this account of the psychological investigations will have to be rather lengthy and, because of the experimental and statistical methods used, inevitably technical in parts. In particular, the Rorschach analysis will be fully understood only by those familiar with this complicated technique, but the results and the discussion of them will, it is hoped, be of interest to others too. As for intelligence tests and questionnaires, these have long ceased to be for specialists only. Most of the available space will be given to Murray's Thematic Apperception Test, because the findings were specially relevant to family relationships. In spite of its rather forbidding title this test is a simple means of stimulating the imagination, and the fantasies it aroused in these young men were analysed by essentially simple and rather novel methods, which will be explained.

When we selected the tests we were seeking answers to the following questions. Are these DU patients more or less intelligent than the controls and do they express their intelligence differently? Are they more or less neurotic than the controls? Do they tend to have a particular type of personality struc-

¹ Senior Psychologist, British Hospital for Functional Nervous Disorders, Camden Town. Formerly, Clinical Psychologist, Medical Research Council's Social Medicine Research Unit.

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ture? Are their fantasies different from those of the controls, as we would expect if their illness is associated with conscious or unconscious psychological conflict? The following tests were chosen.

INTELLIGENCE TESTS

The Wechsler-Bellevue Intelligence Scale for Adults (Form I)

This consists of five verbal and five performance tests from which a Performance, Verbal, and Full Scale I.Q. may be derived (Wechsler, 1944). There is considerable evidence that personality is expressed in the way the subject responds. Though standardized on samples of the American population, it can by a few small modifications be adapted for use in Britain. It has been applied to psychosomatic research (for example, by Krasner & Kornreich, 1954).

SELF-ADMINISTERED PERSONALITY TESTS

The Maudsley Medical Questionnaire and the Crown Word Connection List

The M.M.Q. is a 40-item questionnaire dealing with various physical, 'psychosomatic', and psychoneurotic symptoms of which psychiatric patients frequently complain. The questionnaire is reliable and valid; scores on it correlate highly with psychiatric opinion and with objective tests of 'neuroticism', and patients whom the psychiatrist judges to be more disturbed tend to have higher scores than those judged less disturbed (Eysenck, 1947, 1952, 1957).

The Crown Word Connection List is essentially a standardized version of Jung's Word Association Test. It consists of fifty stimulus words for each of which two responses are provided: one originally preferred by neurotic patients, the other by controls not known to have had any psychiatric abnormality. Although earlier research showed that it discriminated well between 'normal' and neurotic subjects (Crown, 1947) it was shown later (Crown, 1952) that W.C.L. scores tended to have low negative correlations with intelligence test findings and that the W.C.L. had a rather low saturation with 'neuroticism' in a factor-analytic study by Eysenck. Thus this test is not a very good measure of 'neuroticism' and is less effective when given to subjects of higher intelligence.

The Tavistock Self-Assessment Inventory

This test, which consists of a great many items referring to personality and chosen on psychiatric and psycho-analytic grounds (Sandler, 1954), was used in an ancillary investigation of patients with duodenal ulcer, dyspeptics, psychoneurotics, and controls.

PROJECTIVE TECHNIQUES

More than half the testing time at our disposal was devoted to these methods of studying personality which are very well described by J. E. Bell in his book on the subject (1951). This emphasis resulted from the fact that our research was

essentially clinical and guided by psycho-analytic theory, and it was not divorced from psychotherapy. Our efforts were concentrated on achieving the fullest understanding of psychodynamics in each case. In the psychiatrist's face-to-face interviews he had to obtain much factual information, and could employ 'free association' and dream interpretation only to a limited extent. The main purpose of the projective techniques was to provide additional material of an imaginative kind from which unconscious processes could be inferred and further insight into the individual's personality gained. This use of projective techniques can be demonstrated only by clinical studies in which the findings are considered in relation to interview material. Projective test data can also be used for comparing different groups, though for this purpose they are less convenient than simpler and more objective types of test. It is the latter use that will be dealt with here.

The Rorschach Inkblot Test

Opponents of this test, of whom the most active in England is Professor Eysenck (1957, etc.), object that it is neither reliable nor valid: it does not measure accurately and it does not measure what it purports to do. Other experts, for example Professor Philip Vernon in this country (1953), believe that the test in skilled hands is useful in psychiatric diagnosis. In America we find that while Professor Anastasi (1954) was cool and critical, Professor Cronbach (1949a), while fully aware of its shortcomings, was rather enthusiastic. Clearly, whether one wishes to use or burn the Rorschach does not depend only on one's I.Q. or on one's knowledge of the evidence but on other factors as well: one's interests, one's theoretical standpoint, and one's personality. The Rorschach Test reveals the whole mind in action dealing with an unusual and rather disturbing task, and there is a standardized way of investigating and recording this performance. It does not give us an accurate measure of a factor such as intelligence, but it shows us intelligence functioning as a part of the whole personality. There is the incidental advantage that many aspects of a record may be codified, treated statistically, and used in comparative research. The Rorschach, however, remains essentially a means of studying dynamic mental processes in the individual and of discovering personality structure. It is not an accurate method of measuring hypothetical mental factors in groups of people. It has been employed in the study of duodenal ulcer by several investigators whose researches guided our own use of the test (Ruesch, 1948, Brown *et al.*, 1950; Osborne & Sanders, 1950; Kaldegg & O'Neill, 1950; Krasner & Kornreich, 1954).

The Thematic Apperception Test

Like the Rorschach this is a projective technique in which the subject is presented with an ambiguous stimulus and expected to make something of it. In the T.A.T. he is asked to tell a story about a picture (Murray, 1943). A full

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description is given by Bell (1951). Our main aim in using it was to investigate conscious and unconscious conflicts.

If duodenal ulcer has a specific psychopathology, as has been claimed by Alexander (1952), who emphasizes dependence and reactive strivings for independence, and by Garma (1957), whose alternative theory stresses the importance of a bad internalized mother, we would expect the fantasies of D U patients to be different from those of controls.

We had been much impressed by the work of Poser (1952), who was the first to show that patients with duodenal ulcer, ulcerative colitis, and controls could be identified to a statistically significant degree from their responses to T.A.T. cards. His method of describing themes in the manifest content of stories, and then asking impartial judges to classify T.A.T. records, provided the model for our own T.A.T. analysis, and we are greatly indebted to Dr. Poser for his advice and help.

THE DUODENAL ULCER AND CONTROL SAMPLES: MAIN TEST GROUPS

It will be convenient to remind the reader of some facts already stated by Miss Goldberg. Members of the research team originally investigated a sample of 35 D U patients, of whom 31 formed a complete series of all young men found to have duodenal ulcer (by X-ray or at operation) at a well-known gastro-enterological clinic in one year, the other four having been referred from elsewhere.

Members of the team also originally investigated 35 controls. These young men were taken from the list of all those on the register of a general practitioner, after the names had been put in random order and grouped by age. As each patient was enrolled, he was paired with the next control of the same age on our list. Of the first 35 families approached by Miss Goldberg, 27 agreed to co-operate, but she had considerable difficulty in completing the sample.

Both of us drew research subjects from these two samples of 35 patients and 35 controls. But, because of various practical and administrative difficulties, the groups of young men whose test results are presented here do not correspond exactly to those whose families are discussed in her book. From her 32 D U families, 27 patients were psychologically tested, and she has excluded 3 motherless young men who have been retained in the main D U test group of 30 discussed here. From her 32 control families, 30 of the sons have been included in the main control test group of 32 referred to in this appendix, the other 2 test controls also being motherless and excluded by her.

The psychologist also tested some extra subjects, mainly university students, and included their T.A.T. material in the analysis to be described later. Otherwise the psychological test findings presented are those of the main test groups, but sometimes a group will be found to be one short (for example, when a subject did not complete that test).

The main D U test group of 30 contained 85 per cent of the original sample of 35 who, on the whole, must have been fairly representative of young men with duodenal ulcer in that part of London. The main control test group of 32 contained 94 per cent of the original sample of 35, which was probably as representative a group of ordinary young men as can in practice be enlisted in a research project of this kind.

Of the main D U test group, 8 had had surgical operations in connection with their ulcers. Most had had some half dozen psychiatric interviews before being tested. All had been referred to the Unit by their doctors for investigation of their illness. Of the main control test group, all had previously seen the psychiatrist but they had in general had fewer interviews than had the patients. They had agreed to help in a medical research project. These controls proved to be a mixed bag. Six of them had troublesome symptoms for which we thought psychiatric aid was indicated, and there was another who had been in trouble with the police, to say nothing of several with minor neurotic difficulties. About a quarter of the controls in the main test group (including some of those with psychological disorders) admitted to some degree, at least, of indigestion or stomach trouble, though there was little evidence of major dyspepsia.

In several important respects the patients and controls in the main test group were similar. When first tested, the patients ranged from 17 to 25 years of age and 26 of them were 21 years old or more; the controls ranged from 16 to 26 and 26 of them were 21 years old or more. Patients and controls years of age and 23 of them were 21 years old or more. Patients and controls had similar social status: in each group 24 of their fathers were either in Social Class II or III, the majority being in Class III. Ten patients and 20 controls were married. Twenty-three patients and 25 controls had left school at or before the age of 15. Over two-thirds of the young men were in skilled occupations. In the majority of their families both parents were still living.

THE TEST RESULTS

The Wechsler-Bellevue Intelligence Scale for Adults, Form I

All 32 controls were given the Wechsler, as were 29 out of the 30 DU patients.

The results were:

	29 D U Patients	32 Controls
Verbal I.Q.	108.41 \pm 12.10	109.59 \pm 10.15
Performance I.Q.	112.83 \pm 11.40	113.91 \pm 9.15
Full Scale I.Q.	111.66 \pm 11.16	113.00 \pm 9.08

The differences between the groups are small and insignificant.

If we assume the distribution of scores in the British population to be the same as in that of the U.S.A., both these groups are well above average in intelligence. The Wechsler I.Q. Tables are so designed that 50 per cent of the

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population will be found to have I.Q.s between 91 and 110, with 25 per cent above 110 and 25 per cent below 91.

When results on the ten individual subtests were compared only one difference appeared to be statistically significant:

Comprehension: DU Patients 12.69 ± 1.82 ; Controls 11.44 ± 1.92 ; $p < .05$.

This may be a reflection of a difference in personality, for Rapaport *et al.* (1945) interpreted Comprehension as expressing judgment in reality-testing and ability to delay first impulses.

A quite unexpected difference that seemed statistically significant was in words scored half-right in the Vocabulary test (DU Patients 4.07 ± 2.18 ; Control 2.66 ± 1.61 ; $p < .01$). This could also possibly be a reflection of a personality difference.

In evaluating these differences the fact that some two dozen tests of statistical significance were done on the Wechsler findings should be borne in mind.

The Maudsley Medical Questionnaire

The forty items were put in the past tense and made to refer to the time before the subjects had any contact with the Unit. The mean score and S.D. for 31 controls were 10.3 ± 6.6 and for 30 DU patients they were 14.3 ± 6.3 . The difference between the means is statistically significant ($.02 > p > .01$).

The scores were distributed as follows:

	1-5	6-10	11-15	16-20	21-25	26-30	31-35	36-40
DU Patients (30)	3	7	7	8	4	1	0	0
Controls (31)	9	8	8	4	0	2	0	0

There is no doubt that the DU group as a whole had higher neuroticism scores on the M.M.Q. than the control group, but one-third of the patients had scores of 10 or less. Eysenck (1952) reported that the average score of 1,000 normal members of H.M. Forces was 9.98, and, of 1,000 neurotic (discharged) members, 20.01.

Three-quarters of the questions were answered 'Yes' by a larger proportion of DU patients than of controls, and when the number of neurotic responses for each of the 49 questions was taken into account, the difference between the DU and control groups was found to be significant at the $p < .001$ level. The ten questions showing the biggest differences were:

	DU (30) 'Yes'	CONTROL (31) 'Yes'
9. Did you worry too long over humiliating experiences?	19	8
11. Were your feelings easily hurt?	18	10
14. Were you an irritable person?	13	5

	DU (30) 'Yes'	CONTROL (31) 'Yes'
16. Did you use to worry over possible misfortunes?	14	6
18. Did you sometimes feel happy, sometimes depressed, without any apparent reason?	23	15
19. Did you daydream a lot?	15	9
23. Did you worry about your health?	12	6
27. Did your mind often wander badly, so that you lost track of what you were doing?	9	2
30. Did you often feel just miserable?	19	9
36. Were you troubled by aches and pains?	13	4

It may be argued that the answers by the DU patients to several of these questions are just what one would expect from men with a painful physical illness, but Nos. 9, 11, 19, and 27 seem to refer to more basic personality traits than the aches and pains and worry about health, etc. which may well be a consequence of duodenal ulcer.

Eysenck (1947) lists 15 M.M.Q. items answered 'Yes' with significantly greater frequency by the extreme dysthymic male neurotics (those with affective, inhibited traits and symptoms) than by the extreme hysterics (with asocial traits and symptoms). Of these, 10 were answered 'Yes' more frequently by DU patients than by controls, in 6 instances by 50 per cent or more of the DU patients. Eysenck reports that only two items were answered 'Yes' significantly more often by the extreme hysteric males and, to these two, only 13 per cent and 7 per cent of our patients respectively gave positive answers. This suggests that our young patients with duodenal ulcer tended to belong to the dysthymic (introverted) rather than to the hysteric (extraverted) category.

The Tavistock Self-Assessment Inventory

Brief mention must be made here of an ancillary study of men below the age of 39 with duodenal ulcer or functional dyspepsia who had attended the same gastro-enterological clinic and who were compared with a control group drawn from the same general practice (Kanter & Sandler, 1955). Some of the patients and controls in our main test groups took part in this study too. All completed the Tavistock Self-Assessment Inventory of 876 items. Sandler & Pollock (1954a) had shown that 54 items were significantly associated with a syndrome of 'functional dyspepsia' in neurotic men. Neurotic men admitting to dyspepsia had significantly higher scores on this scale than neurotic men not admitting to dyspepsia. Kanter & Sandler, using 53 items of this scale and a subscale of 7 items judged unlikely to be a consequence of dyspepsia, analysed the scores of three groups of DU patients, and also one group of dyspeptic neurotics, one of non-dyspeptic neurotics, one of functional dyspeptics, and

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SUMMARY OF RORSCHACH FINDINGS

	Rorschach Scores	30 Duodenal Ulcer Patients		32 Controls from a G.P.'s Register	
		Mean	S.D.	Mean	S.D.
Total Number of Main Responses R		22.70	11.33	22.60	12.91
Number of Cards rejected	Reject.	0.60	0.88	0.78	1.27
Whole Plot Location	W	8.50	4.11	8.31	5.22
Large Usual Detail	D	10.87	8.05	10.00	6.94
Small Usual Detail	d	0.97	1.91	1.25	2.35
Unusual Detail, Black or White	ddS	2.37	3.46	3.03	3.77
Human Movement Determinant	M	3.27	2.62	2.72	2.27
Animal Movement	FM	4.17	2.73	4.03	2.57
Inanimate Movement, e.g. Drifting Clouds, etc.	m	0.93	1.15	1.44	1.73
Shading used, e.g. for X-rays, Relief Maps, etc.	k	0.70	0.90	0.56	0.75
Shading as Diffusion, e.g. Smoke, Clouds	K	0.25	0.48	0.41	0.70
Shading in Vista or Perspective	FK	0.50	0.92	0.56	1.06
Form only	F	8.10	5.35	7.72	6.81
Form with Shading as Surface Texture	Fc	1.23	2.06	1.59	1.39
Form inaccurate	F-	0.53	0.89	0.47	0.87
Shading alone used for Texture, etc.	c	0.47	0.81	0.41	0.74
Black or White used as Colour	C	0.47	0.89	0.47	0.71
Definite Form with Bright Colour	FC	1.27	1.09	1.19	1.21
Bright Colour with Indefinite Form	CF	1.30	1.24	1.25	1.75
Bright Colour only	C	0.10	0.30	0.25	0.50
Human Beings as Content	H	3.30	2.73	2.78	2.41
Parts of Human Beings	Hd	1.57	2.20	1.34	1.67
Animals	A	8.23	4.33	8.25	4.24
Parts of Animals	Ad	1.83	2.10	1.69	2.71
Anatomical Content	At	0.97	1.08	1.03	1.67
Popular Responses, most fre- quently given	P	5.17	1.88	4.56	1.75
Main and Additional Original Responses, rarely given	All O	3.23	2.25	4.50	2.21
Main and Additional Responses to White Spaces	All S	1.57	1.02	1.78	1.98

APPENDIX I

	Rorschach Scores	30 DU		32 Controls	
		Mean	S.D.	Mean	S.D.
Weighted Value of Bright Colour Responses	Sum C	2.08	1.44	2.28	2.33
Percentage of R to last 3 Coloured Cards	8, 9, 10%	33.93	12.32	32.97	9.48
Percentage of R with Definite Form only	F%	34.03	14.27	31.47	14.90
Percentage of R with Definite Form	F+%	84.33	8.92	85.16	12.83
Time taken for each Response	Time per R	60.63	27.14	87.59	63.02
Initial Reaction Time to Card I	Int. R/T	10.07	5.77	15.19	14.41
Initial Reaction Time to Black and White Cards	R/T Mon.	17.73	9.58	24.63	16.03
Initial Reaction Time to Cards with Colour	R/T Ccl.	21.13	13.31	26.69	15.75
Initial Reaction Time to All 10 Cards	All R/T	19.23	11.16	25.81	14.78

Notes

1. The table summarizes some of the findings. Since the means and standard deviations of Rorschach scores are affected by the number of responses, caution will be needed if these figures are compared with similar data from other researches.
2. In this part of the study 62 comparisons were made.
3. The following ratios were compared: $M : \text{Sum } C$; $FM + M : Fc + c + C^1$; $W : M$; $M : FM$; $FC : CF + C$; $H + A : Hd + Ad$; $H + Hd : A + Ad$; $M + \text{Add. } M : FM + \text{Add. } FM$; $FC + \text{Add. } FC : CF + C + \text{Add. } CF + \text{Add. } C$.
4. Statistical significance was assessed by means of the *t* test. All scores except R, Rejections, Sum C, P and the ratios, were converted to percentages of the total number of responses. The differences tested were those between 30 records of patients and 30 of controls matched for number of responses.
5. The following differences were found to be statistically significant:

All m (main plus add.)	$p < .05$	(DU less than controls)
All O (main plus add.)	$p < .05$	(DU less than controls)
R/T (Monochrome)	$p < .05$	(DU less than controls)
R/T (All cards)	$p < .05$	(DU less than controls)
Time per response	$p < .01$	(DU less than controls)

(The following differences were found to have occurred at a level between $p < .05$ and $p < .10$)
 Popular (DU more than controls); K, R/T Coloured (DU less than controls).

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one of controls. It was shown that all the dyspeptic groups, whether the diagnosis was duodenal ulcer or functional dyspepsia, were not significantly different on these two scales from neurotic men with dyspepsia attending a psychiatric clinic. Moreover, controls from the G.P.'s list admitting to dyspepsia had an average score almost as high as that of dyspeptics who had attended the gastro-enterological clinic.

These two scales were interpreted as measures of 'nervousness'. They were clearly not measures of neurosis as such, for the average score of non-dyspeptic neurotic men was no higher than that of the controls. It appears, however, that there is one class of neurotic men who have dyspepsia, and that patients with duodenal ulcer or functional dyspepsia tend to resemble them in being prone to similar anxieties. It may be that the dyspeptic type of neurotic male tends to resemble Eysenck's dysthymic type. In a factor-analytic study (1947) Eysenck found 'dyspepsia' to have saturations with neuroticism (0.54) and dysthymia (0.17).

The Crown Word Connection List

The mean scores and standard deviations were:

30 DU patients 10.23 ± 4.56 . 31 controls 9.90 ± 4.96 .

The differences are quite insignificant.

The correlations between W.C.L. and M.M.Q. scores were:

+0.087 for the controls and +0.120 for the DU patients.

Rorschach Findings

All Rorschach records were scored according to the method described by Klopfer and Kelley (1946). The statistical analysis was planned and executed by the Unit's statistical staff after a study of Cronbach's paper on this matter (1949).

In the table on p. 234-5 will be found the means and standard deviations for the main location, determinant, content, and time scores in both samples. It is clear that the DU and control groups are in most respects similar; a few small differences can be seen among the determinants and location and content scores; larger differences appear among the time scores.

It was decided *not* to carry out tests of statistical significance on these figures, chiefly because almost all scores for locations and determinants are positively correlated with the number of responses in a record. We began, therefore, by ranking all the records in order of their total numbers of main responses. There were 30 patients and 32 controls in the main test groups, and their records were found to be fairly well matched for length; the two control records which fitted least well were then removed and we were left with 30 pairs of records very similar in length. The significance of the differences in proportions between pairs was assessed by means of the *t*-test. Main determinant, location, and content scores were expressed as a percentage of total R in any given record. When main plus additional responses were considered in any scoring category,

the sum was regarded as a percentage of the total of main and additional responses in the record. Comparison of ratios was based on matching for the first variable in the ratio.

Out of 62 comparisons made, only 5 yielded results which appear to be statistically significant at the $p < .05$ level and these among so many *could* have occurred by chance; only one of these (Time Per Response) appears to be significant at the $p < .01$ level. The differences in timing cannot be taken very seriously, since times had not been very accurately recorded and a minority of individuals had been responsible for the apparent group differences. That our control group seems to have significantly more Original responses than our DU group may raise a sceptical smile in critical readers, for the O score is the most subjective of all and one of our hypotheses was that the patients were more conventional; but the scoring of Popular responses is quite objective, and if we used a one-tailed test here, as we justifiably could, the patients would appear to have significantly more P, a finding which would be quite consistent with their lower O score.

The controls give more main and additional m (possibly significant at the $p < .05$ level). Following Klopfer and Kelley (1946), the psychologist had assumed m to be a pathological sign of tension. It was only later that he learned from Dr Klopfer (personal communication) that, on the basis of a study of American Air Force pilots, he had reinterpreted m as a sign of tension-tolerance. In the DU group the mean main m score was 0.93 with S.D. 1.15, and the mean additional m score was 1.50 with S.D. 1.48. In the control group the mean main m score was 1.44 with S.D. 1.73, and the mean additional m score was 2.13 with S.D. 2.42. The m determinant is often found in association with the K type of shading determinant in such responses as 'dark smoke rising'. In the DU group the mean K score was 0.20 with S.D. 0.48, and the mean additional K score was 0.83 with S.D. 1.04. In the control group the mean K score was 0.41 with S.D. 0.70, and the mean additional K score was 1.16 with S.D. 1.84. The usual interpretation of K is that it signifies free-floating anxiety, and, if these differences in m and K scores were not merely the result of chance factors, it might be suggested that in the Rorschach situation the controls tended to experience and express more free-floating anxiety than the patients and to be better able to tolerate the tension.

The main conclusion of this 'standard' Rorschach comparison of 30 young men with duodenal ulcer and 30 ordinary young men must be that their Rorschach records when matched for length and scored according to the Klopfer and Kelley system were in almost all respects remarkably similar.

There is no room here to compare these findings with those of all the other Rorschach investigations in the literature, some of which claim certain features as characteristic of ulcer patients that were not shown to be so in our own study. Our findings are, however, in close agreement with those of Krasner and

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Kornreich (1954). Among published studies based on the standard Rorschach research method, theirs is outstanding on account of its admirable design, its careful choice of appropriate experimental, control, and contrast groups, and its statistical sophistication. Their ulcer patients were men under the age of 40 diagnosed as having *duodenal* ulcer at a general hospital and were on the whole above average in intelligence; thus, in spite of their different cultural background and tendency to be older, they resembled our own patients in some important respects.

Krašner and Kornreich compared four groups by means of the Wechsler and the Rorschach. 'Two were experimental groups, 25 patients diagnosed as having duodenal ulcer and 25 patients diagnosed as having ulcerative colitis.' The control groups were '25 patients diagnosed as having anxiety neurosis and 50 "non-psychosomatic" patients hospitalized for pilonidal cyst or inguinal hernia. All patients were white male veterans of World War II, between the ages of 20 and 40. Three groups (duodenal ulcer, ulcerative colitis and "non-psychosomatic") were selected at a V.A. general hospital. These patients were the first of their diagnostic category who met the criteria and who entered hospital after January 1, 1949. The anxiety neurotics were the first 25 patients meeting the criteria at a V.A. mental hygiene clinic after October 1, 1949.' Their main conclusion was: 'In view of the number of comparisons made between the various groups, the finally remaining significant results are no more than one would expect by chance. Thus, if one adopts a stringent statistical criterion alone, Rorschach scores are unable to differentiate between the groups.' The mean Wechsler-Bellevue I.Q. of their DU group was 109.08, and that of their control group was 113.10, fairly similar to those of our groups. Mean numbers of responses were lower, 17.76 and 19.96 respectively. The scoring system used, Piotrowski's, was rather different from ours. Nevertheless their duodenal ulcer patients gave fewer m than their controls and either of their other groups, and they also gave a higher percentage of Popular responses than their controls or either of their other groups.

Special Rorschach Investigations (Briefly Summarized)

Some of these were inspired by previous research.

1. *Signs of Neurosis and Adjustment.* When the Miale and Harrower-Erickson nine neurotic signs (1942) were applied to the Rorschach records no significant differences were found between the DU and control groups (30 DU: 4.00 ± 1.83 ; 32 controls: 4.31 ± 2.16). Likewise no significant differences were found when Davidson's signs of adjustment (1950) were used (30 DU: 8.47 ± 3.00 ; 32 controls: 7.97 ± 2.94).

2. *Introversion-Extraversion.* Of the DU group 60 per cent were introversive, as were 50 per cent of the control group on the main M : Sum C index. The phenomenon of reversal of experience type in DU patients reported by Poser

(1951) was found unambiguously in only 4 DU and 3 control records. Different types of personality structure were observed within the DU group and also within the control group.

3. *Signs of Homosexuality.* These signs (Wheeler, 1949) were applied to the Rorschach records of the DU patients and controls, following the precedent of Marquis, Sinnott, and Winter (1952). Of the patients, 13 (43 per cent) had 3 or more signs, compared with 10 (31 per cent) of the controls. The difference, although in the expected direction, is not statistically significant.

4. *Oral Aggression.* Oral aggression and oral dependence were scored by the method of content analysis devised by De Vos (1952), as had been done by Streitfeld (1954) in his study of peptic ulcer patients. Our results were: Oral Aggression—Patients 8, Controls 11; Oral Dependence—Patients 6, Controls 9. Using a more liberal definition of oral aggression, the psychologist found at least one oral-aggressive response in 16 out of 30 DU records and in 15 out of 32 control records.

5. *Anxiety and Hostility.* Elizur (1949) devised a method of assessing anxiety and hostility in Rorschach records which was found to be fairly reliable and to have some degree of validity. When this was applied to our records, no significant differences were found between the DU and control groups. There was a slight tendency for the patients to have lower scores in both anxiety and hostility.

THE RORSCHACH TEST: RESULTS AND DISCUSSION

The standard analysis of the Rorschach records showed the main DU and control test groups to be very similar in most respects. The special Rorschach inquiries also showed many more similarities than differences. This general similarity of Rorschach scores is no doubt partly due to the deficiencies of the Rorschach test used in this way as a means of psychological measurement. On the M.M.Q. the DU group tended to have higher neuroticism scores than the control group but the Miale and Harrower-Erickson signs of neurosis showed no difference. We expected other and larger differences than those we found, if only because of the effects of illness in the DU group.

On the other hand, this general similarity in Rorschach scores is consistent with our clinical impression that the personalities of the DU patients and the controls were not strikingly different. Duodenal ulcer and dyspepsia are very common in the general population, and neurotic disorders are widespread too, so there is little reason to think that DU patients at a general hospital will be much more psychiatrically abnormal than controls from a general practice.

The writer agrees with Vernon (1953), who states: '... the skilled Rorschach tester can certainly help in the differential diagnosis of mental patients. He seems, however, to be less able to make valid predictions about normal persons.' It is for the purposes of differential diagnosis in the psychiatric clinic that the

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Rorschach is most useful. The patient seeking psychiatric help probably tends to have a different attitude to this test from that of the research subject. The Rorschach interpreter in the clinical situation does not depend on scores only, but can take full account of the content and sequence of responses in a record.

There are differences (if only of degree) between the personalities of DU patients *en masse* and those of other men which are probably reflected in their Rorschach records but tend to escape the wide mesh of ready-made scoring systems. Nevertheless, the few differences which were observed in our Rorschach investigation are consistent with other test findings, with clinical observation, and with psychosomatic theory.

The Rorschach evidence suggests that the DU patients are less tolerant of tension than the controls, which would give some support to the hypothesis that a duodenal ulcer is to some extent a consequence of tension, and would be consistent with their tendency to have higher M.M.Q. (neuroticism) scores. The patients appear to be more conventional than the controls and there are also suggestions in the M.M.Q. and Wechsler that they tend to be socially conforming and self-controlled; moreover, Miss Goldberg has stressed their good behaviour as children and adolescents. There is some indication in the Rorschach that the DU patients tend to be more introversive than the controls, and though Rorschach's introversion is not the same as Eysenck's, this points in the same direction as the M.M.Q. findings. There is also rather more evidence of homosexual tendencies in the DU group; Wheeler found these signs were associated with hostility to, and identification with, the mother.

THE THEMATIC APPERCEPTION TEST

An Attempt to Combine Experimental Method and Psycho-analytic Interpretation Extra Cases

There were 8 extra DU patients, 7 of these being university students who had been investigated as a contrasting group, and one an Irishman who appeared in the hospital series. There were 4 extra controls, two of them brothers of DU patients and two motherless young men from the original control series. Their families, with one exception (that of the brother of a DU patient in the main test group), have not been included in Miss Goldberg's study.

T.A.T. Cards Used

The Thematic Apperception Test (Murray, 1943) consists of series of pictures, most of these being drawings of the kind found in magazines to illustrate stories. The testee is asked to make up stories about the pictures—what is happening now, what the characters are thinking and feeling, what happened previously and what the outcome will be? There is also a Blank Card on which the subject is asked to imagine a picture. The T.A.T. is a means of stimulating

fantasies (akin to daydreams) in the subject from which his main concerns and conflicts, conscious and unconscious, may be inferred.

The cards administered to almost all the patients and controls in the main test groups were the following: Nos. 1, 2, 3BM, 4, 5, 6BM, 7BM, 8BM, 10, 16 (Blank Card), 11, 12M, 13MF, 17BM, presented in that order. The university students, and a few subjects in the main test groups, were given additional cards which were disregarded in the analyses to be reported here.

Preliminary Analysis of Half the Records—'The Criterion Sample'

With sufficient ingenuity and pertinacity, an investigator might differentiate any two groups with an accuracy very much higher than would be expected by chance, for instance, merely by listing all the unique peculiarities of the individuals in each. If, however, differentiating features were found in two samples and the same features were subsequently found in two other similar samples, it would be more justifiable to regard them as *typical* of the populations concerned. We therefore decided to split the T.A.T. material into two portions and to predict, from differences found in the first, those that would be found in the second.

The basis for choosing 15 T.A.T. records from DU patients to compare with the first 15 that were obtained from controls was the fact that the young men in the two samples had already been paired for age, and 11 of the 15 DU records were simply those of the paired patients concerned. In the 4 other cases it was necessary to pair anew, partly for administrative reasons and partly to avoid disparity in amount of T.A.T. material. The patients tended to have been early referrals. These two subgroups of 15 were called the 'Criterion Sample'.

Search for Differentiating Features

The T.A.T. material produced by the DU patients and that by controls for each of the 15 cards was analysed separately. Extracts from every story were copied under these headings: (1) Characters; (2) Interpersonal Relationships; (3) Present Situation; (4) Previous Situation; (5) Outcome; (6) Thoughts and Feelings; (7) Perception and Criticism; (8) Length. With reference to the last two, little evidence of faulty perception or of criticism of the pictures was collected either in these two groups or in the remainder of the samples when studied later, and no significant differences between the main DU and control test groups in length of stories was found. Attention was concentrated on the content of the stories, and the aim was to find in the manifest material differences that could be reliably scored. The psychologist was guided by certain very general hypotheses concerning the degree of dependence and independence, aggression and passivity, anxiety and confidence, emotion and apathy, which might differ in the two groups. When, for example, the extracts from Card 6 stories in the column headed 'Interpersonal Relationships' were scrutinized, it was

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observed that one theme occurred in 5 stories by controls, namely that the hero was going to get married:

- (No. 3) 'A young fellow who has decided to leave home to get married. . . . His mother tries to plead with him to stop at home.'
(No. 15) 'Her son had just told her he was getting married and would be moving away. . . . A heated argument ensued.'

When marriage was mentioned (twice) in the DU group, the storyteller was less positive:

- (No. 8) 'I should say he's got to go in the Army or he's getting married. No, not getting married, something he doesn't like doing.'

In the stories told by patients in the same column, a different theme was clearly discernible and occurred in nine cases:

- (No. 2) 'When he was quite young his father was killed building a bridge. . . . Made up his mind he'd study hard and carry on where his father had left off.'
(No. 4) 'Her husband probably had some sort of accident at work, like . . . an official of the firm's come round to tell his wife of the accident.'

This theme—the woman's husband imagined as dead, dying, or injured—was only found in one story by a control, and then it was in conjunction with the marriage theme:

- (No. 15) 'This young man's name was Bill. He and his mother had lived very happily since he was old enough to support her. Her world was very rosy after she had got over the loss of her husband. But now it seemed that it was all collapsing around her. Her son had just told her he was getting married and would be moving away.'

Such features were marked with code letters. Eventually, criteria for scoring them were defined:

C. *Positive Attitude to Marriage*: 'The man is going to get married, and no doubt or alternative interpretation is expressed by the storyteller.'

G. *Her Husband's Death or Injury*: 'It is stated that the woman's husband actually or possibly is dead or dying, or that he has been injured or that she is or may be a widow.'

This procedure was followed for the other 14 cards too, and in the first analysis of the material 45 differences in items occurring at least twice in one of the groups and in a ratio greater than 2 : 1 in favour of either group were discovered; they were distributed over all the cards except 12M, and the largest number had been observed on Card 6 BM. Features preferred by the DU patients were called DU Signs, those preferred by controls, Control Signs. When all 15

stories were included it proved possible, simply by giving each sign the same value of 1 point and subtracting the number of DU Signs from that of Control Signs or *vice versa* in each individual record, to obtain scores which differentiated the Criterion DU and control groups almost perfectly; fourteen of each were identified. The results of this crude analysis were encouraging, especially as it was not difficult to think of a plausible psychological explanation of the differences observed. The experiment seemed to justify a thorough analysis of all the T.A.T. material in a similar but more refined manner.

METHODOLOGICAL PILOT STUDY USING CARD 6

(a) 'Blind' Scoring by Independent Investigators

As a first step, it was decided to carry out a pilot study using one card only, namely Card 6 BM. 'A short elderly woman stands with her back turned to a tall young man. The latter is looking downward with a perplexed expression' (Murray, 1943). This card had not only revealed the largest number of differences but was especially relevant to the team's hypotheses concerning the mother-son relationship in DU patients.

The stories for all 38 patients and 36 controls were extracted from their typed records. Names and diagnoses were omitted, as were statements in response to the 'Inquiry' in which the examiner had tried to get further information about obscure points in the stories spontaneously told. The stories were numbered and arranged in the alphabetical order of the story-tellers' names, but there was no way of telling which was which without a key, except possibly from the stories themselves. They were then sent to three independent investigators. The colleagues who kindly agreed to help were Miss (now Dr) Ann Tatlow, a clinical psychologist; Mr Herbert Phillipson, also a clinical psychologist, the inventor of The Object Relations Technique; and a consultant gastro-enterologist at the clinic concerned, who must remain anonymous and will be referred to as Dr C. G.

Standardized instructions, criteria for scoring derived from examples in the Criterion Sample, and scoring sheets were sent to each of them. Each was asked to score the presence of any of nine differentiating features in every story. These were: A. Leaving Home; B. Broken Relationship; C. Positive Attitude to Marriage; D. Conflict Between Them; E. Delinquency; F. Work Trouble; G. Her Husband's Death or Injury; H. Her Husband's Effect upon the Man; I. Strong Emotion. The only criterion that calls for explanation here is that for H, which was to be scored if the behaviour of the young man in the picture was determined by the death or by some event in the life of the woman's husband. The scoring of each feature seemed fairly simple and therefore probably reliable, and each feature as scored had occurred in the ratio of 2 : 1 at least in favour of either the DU or control group in the Criterion Sample.

The psychologist also scored the remaining 44 cases for these nine features.

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(b) Reliability of Scoring

DEGREE OF AGREEMENT ON THE PRESENCE OR ABSENCE OF A
FEATURE (PERCENTAGES)

	A	B	C	D	E	F	G	H	I
<i>judges agree</i>									
All cases	74	73	100	72	84	84	91	91	50
30 Criterion Sample	83	87	100	60	97	87	87	87	53
44 Remaining	68	64	100	80	75	93	93	93	48

The degree of agreement was generally quite high, but this was partly because there was little difference of opinion when a feature was conspicuously absent. Agreement on the *presence* of a feature only tended to be lower.

1.

DEGREE OF AGREEMENT ON THE PRESENCE OF A FEATURE (PERCENTAGES)

	A	B	C	D	E	F	G	H	I
3 or 4 judges agree									
All cases	69	32	100	70	65	41	94	58	67

(c) Differential Weighting

As the different features had occurred in varying ratios between the DU and control groups in the Criterion Sample, it was clear that they would probably not all carry the same weight in the discrimination of the Remainder. To devise a suitable weighting system was treated as a purely statistical task. Dr Joseph Sandler kindly provided a table of weighted scores,¹ and these when applied to the psychologist's scoring of the Criterion Sample led to the correct identification of 14 DU patients and 15 controls, as shown below. (The weighted values found in the response of any one story-teller were combined to give either a plus score, a minus score, or zero.)

WEIGHTED SCORES (V.K.) OF CARD 6 STORIES IN CRITERION SAMPLE

[illegible]

¹ 'The weights in the table which you have, have been derived as follows:

$$w_1 = K \cdot \frac{\Phi_{ic}}{S_1}$$

where w_i is the weight for item i ; Φ_{ic} is the point product-moment correlation coefficient (phi-coefficient) between the item and the criterion, and s_i is the standard deviation of the item for the whole group'. (Dr J. Sandle, personal communication).

(d) *Attempts at Discrimination*

We now proceeded to work out weighted scores for the independent investigators on all 74 stories. V.K.'s scoring of the differentiating features in the Criterion Sample determined the weights (A—3, B—5, C—5, D—4, E—2, F+4, G+5, H+6, I—4).

The cutting-point was found which gave for each individual judge's score the best discrimination in the Criterion Sample. If there were two possible cutting-points, each of which would identify the same total, that which identified the greater number of DU patients was chosen. Finally, a cut was made at the same point in the scores of each judge for the remaining 44 cases. The results were:

	Criterion Sample		Remainder Main Test Groups		Extra Subjects	
	D U	CONTROL	D U	CONTROL	D U	CONTROL
A.T.						
Cutting-point — $5\frac{1}{2}$						
Identified	13	15	9	10	5	3
Misidentified	2	0	6	7	3	1
C.G.						
Cutting-point — $5\frac{1}{2}$						
Identified	13	12	8	10	6	3
Misidentified	2	3	7	7	2	1
H.P.						
Cutting-point — $4\frac{1}{2}$						
Identified	13	13	9	10	7	4
Misidentified	2	2	6	7	1	0
V.K.						
Cutting-point — $5\frac{1}{2}$ *						
Identified	14	25	9	9	5	2
Misidentified	3	0	6	8	3	2

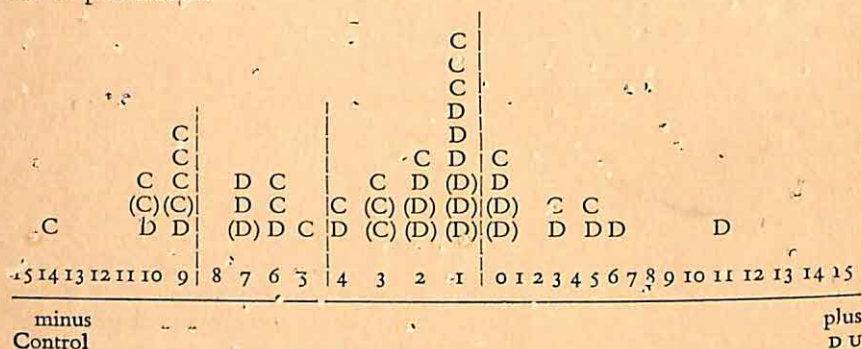
*The cutting-point as shown in the histogram (opposite) was actually —6, but two DU patients and one control in the Remainder were found to have scores of —6. By taking — $5\frac{1}{2}$ rather than —6 we derived no advantage from this knowledge.

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The scoring of all four judges when applied to the Criterion Sample succeeded in classifying the great majority correctly. But when the classification of the Remainder is considered the result is in only one example, that of H.P., significantly better than would be expected by chance ($p < .024$).

(e) H.P.'s Scoring Re-examined

H.P. had not, however, scored the differentiating features in the Criterion Sample in exactly the same way as V.K., probably because he had interpreted the scoring criteria rather differently. Consequently the ratios of the differentiating features between the two Criterion Groups were not the same for H.P.'s scoring as for V.K.'s. The nine differentiating features were, therefore, re-weighted according to H.P.'s scoring of the Criterion Sample stories (A—2 B—3 C—5 D—4 E—1 F+5 G+5 H+6 I—1). The optimal cutting-point was again $-4\frac{1}{2}$. In the Criterion Sample all with scores of 0 to +16 were D U patients (11). All with scores of -9 to -15 were controls (7). Here is a histogram of the scores of the Remainder on H.P.'s re-weighted scoring; extra cases are in parentheses:



H.P.'s results for all groups after re-weighting his scoring were:

	Criterion Sample (30)		Remainder Main Test Groups (32)		Extra Subjects (12)	
	D U	CONTROL	D U	CONTROL	D U	CONTROL
Cutting-point $-4\frac{1}{2}$						
Identified	14	11	10	8	7	2
Misidentified	1	4	5	9	1	2

The discrimination of all three samples is rather less successful than before, but it is interesting that when the stories of the Remainder are considered there

are 7 controls with scores of -9 to -14 but only 2 DU patients and there are 7 DU patients with scores of 0 to +11 but only 3 controls. This suggests that there tended to be a real and typical difference in the occurrence of certain types of story between the two groups both in the Criterion Sample and in the Remainder. It may be that discrimination failed to be so successful in the Remainder partly because of insufficient reliability of the test and of the scoring.

(f) *Evaluation of Card 6 Pilot Study*

We know from the M.M.Q. and Rorschach evidence that in both the main DU and control test groups there were probably different types of personality, some more neurotic and some less, some introversive and some extravertive, and so we should expect different types of response to the T.A.T. within each small group. There can be no doubt that the very good discrimination obtained by all judges in the Criterion Sample was made possible by including chance differences among the differentiating features as defined by the scoring criteria. This is illustrated by the scoring of each of the nine features when 3 or 4 judges agreed:

		Control signs						DU signs		
		A	B	C	D	E	I	F	G	H
Criterion Sample	15 DU	6	0	0	4	2	5	4	9	6
	15 C	8	4	5	10	3	7	0	1	0
Remainder	23 DU	5	2	0	9	2	10	2	4	1
	21 C	10	2	3	10	6	10	1	2	0

In the Criterion Sample the scoring of, for instance, B (Broken Relationship) and D (Conflict between Them) indicated considerable differences between the DU and control groups which disappeared in the Remainder. Some items, however, were scored in the ratio of 2 : 1 or more and in the expected direction in the Remainder. These were A. Leaving Home, C. Positive Attitude to Marriage, E. Delinquency, F. Work Trouble, and G. Her Husband's Death or Injury. It is interesting that the DU patients less often bring in the theme of leaving home. Though the item was seldom scored, evidence of anxiety about work was found more often in the DU group. It is the controls who more frequently introduced criminal activities. Miss Goldberg has stressed her finding that the DU families are respectable and conforming on the whole and the DU patients were inclined to be unaggressive in their behaviour as children and adolescents.

The marriage theme (C) was scored only in control stories and the dying husband theme (G) was found much more frequently in DU stories. (It will

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be recalled that these two features were the most reliably scored of the nine.) This most interesting contrast, which seems to be related to independence of, or dependence on, the mother, is fully discussed later.

(g) *Examples of Card 6 Material*

Some actual examples of the stories told by DU patients and controls will make these experiments clearer. In the table on p. 247 it has been shown that one feature, C (Positive Attitude to Marriage), was scored by either 3 or 4 judges in 8 control stories (22 per cent of 36 cases) and in no stories by patients. Another feature, G (Her Husband's Death or Injury), was scored by either 3 or 4 judges in 13 stories by DU patients (34 per cent of 38 cases) and in 3 stories by controls (8 per cent of 36 cases). There was usually a marked contrast between the stories containing the one feature only and those containing the other. Here is a story told by a DU patient in the Criterion Sample in which G was scored:

- 1a. 'All got worried looks on their faces, ain't they? Seems a case of father, mother, and son—have always led a happy life in their home in the outskirts of London. And the father being keen on horses—just goes for his regular morning ride. This particular morning he was riding down a lane about a mile from home and a cat scampered across the road in front of the horse. Frightened the horse so much he bolted and threw the father into the roadway. Being taken to hospital in an unconscious state. Mother and son was notified and they come up to the hospital to see their father (mother and son, in' it?). While waiting outside in the corridor thinking of all the happy days they've had together. No accident, never a row. Son thinking what a great father, nian he was. And the doctor came out and announced that her husband had died without regaining consciousness. That seems to account for the despair on their two faces.'

The next two stories (both scored for G) were told by DU patients, the first (2a) by one of the extra university students, the second (3a) by one of the main DU test group (Remainder).

- 2a. 'Well the first thing that crossed my mind here—a difficult discussion between son and mother, and they are not obviously agreeing. Attitude of mother. Handkerchief in hand, she's been emotionally upset and . . . er. Well, I'm changing my mind now—son's got his coat on, hat in hand and he might well have been coming back home from somewhere. It could be a sad scene, son breaking the news of father's very ill-health or death to the mother. On the other hand, could be any other member of the family, the son's wife or anybody else. Seems to be an atmosphere of silence at this very moment which probably means they are ranging their thoughts in order to know what to do next. I should say that if it is really the loss of the father

there's obviously no psychological problem as far as the son is concerned because he obviously becomes the head of the family. My impression is that they are now more concerned with their sorrow than with their future plans.'

- 3a. 'Um . . . well it seems there's these two people in the house. It seems like something's happened. Someone might be dying. I'd say it was the chap's father—this chap here, and, er, this woman here would be, you know, the father's wife. And they're both anxiously waiting you know for the nurse and doctor to come out and tell them what the result is. That's all there is.'

Next, here is a story told by a control (Criterion Sample) that was scored for G. It will be seen that it also contains the marriage theme.

- 1b. 'This young man's name was Bill. He and his mother had lived very happily since he was old enough to support her. Her world was very rosy after she had got over the loss of her husband. But now it seemed that it was all collapsing around her. Her son had just told her he was getting married and would be moving away. A heated argument ensued and she finally refused to have anything more to do with him. He got married and lived quite happily, but on occasions thought of his mother, alone. He wrote to her once, twice, three times. Having received no reply he went along to see her. She was quite well but still refused to have anything to do with him. So he left it at that.'

The following story was told by a control in the Criterion Sample and every Control Sign except E was scored by 3 or 4 judges in it:

- 1c. 'A young feller who has decided to leave home to get married and goes to his mother to tell her about it. When leaving, his mother tries to plead with him to stop at home and that if he leaves he is making a big mistake. On refusing to stay his mother tells him that she wants nothing more to do with him which leaves him broken-hearted. That's all.'

Here is another story from one of the controls in the Remainder of the main test group which was scored for the same features as the above with the exception of B (Broken Relationship).

- 2c. 'This is a woman's son who has come to tell her that he is getting married. His mother objects to this marriage as she thinks this woman is no good, but her son is determined to marry no matter what happens. And so he marries her leaving his mother with a sad heart. As time goes by this man's wife starts going with other men. He gets to find out this and puts in for a divorce. He gets his divorce and goes back to his mother and his mother is very pleased with what he has done.'

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The next example is a story told by a patient in the main DU test group who was not in the Criterion Sample. It was scored for item F (Work Trouble) by the majority of judges.

- 1d. 'We seem to have a picture of mother and son. Mother is one of the fine old grey-haired ladies with becoming eyes for her age and delicate wisps of white hair. Her taste of dress being in perfect keeping with her age. The son seems to be a smartish business man and both have a great problem on their minds. It seems as though the son has told his mother some bad news. He has probably asked for some kind of financial assistance. Mother appears to be shocked and dazed by the news but despite her womanly instincts and her present emotions, feels that the son although young must learn to stand on his own feet. The son, a handsome youth with considerable kindness toward his mother, is worried, and a look of almost hatred has crept into his eyes because she is not helping him. He may even in his own mind have considerable bitter thoughts as to what he would like to say to her. I should think the outcome would be that the mother discreetly and unknown to the son does financially help him. And that the son, relieved at having got out of his scrape, returns with full affection for his mother to tell her the good news, and to thank her for making him stand on his own feet and get himself out of a mess.'

The last example is a story by a control in the Remainder of the main test group. The presence of item E, Delinquency, is very obvious.

- 1e. 'This lady; the old lady, she was all alone, had no family but one grandson. The grandson used to come and see her and go away for a week and come and see her. She never knew where he was or what he was doing. Until one day he came to see her and he told her that he made a big mistake. He would never see her again, she might hear of him but not from him, or see him. A month later there was a knock on the door, the young man, a very grave expression on his face. He told her that her grandson had been a big time gang leader that had been killed in a gun battle with the police. I think that's about all for that one.'

(h) Card 6. *Blind Analysis* by Dr Frieda Goldman-Eisler

After reviewing the work reported above the writer thought that the evidence strongly suggested a contrast in stories told by the DU patients and controls, which was perhaps not adequately measured by his scoring system. He therefore decided to try a new approach to the problem.

As a first step we drew a new Criterion Sample of 24, at random from the list of 38 DU patients and 36 controls. Among the 12 DU patients chosen were 8 of the former Criterion DU group; among the 12 controls 4 of the former

Criterion control group. The 12 stories from the DU patients were typewritten and labelled 'X' group; the 12 stories from the controls were copied likewise and headed 'Y' group. Through an intermediary we approached Dr Frieda Goldman-Eisler, the experimental psychologist, who was then working at the Maudsley Hospital, and asked her to examine these stories, looking for similarities and differences between those of X and Y groups, and to write down any evidence of recurrent and characteristic psychological differences. Dr Goldman-Eisler was not informed till the completion of the experiment that the groups consisted of DU patients (X) and controls (Y), nor that the material had come from the Social Medicine Research Unit. There were no marks of identification on any of the test material submitted to her, and she was asked not to discuss this experiment with colleagues until it was completed. When we had been informed that the material had been examined, we sent our intermediary the book containing all 74 responses and Dr Goldman-Eisler was then asked to identify the remaining 50 stories. The results showed that the discrimination obtained in this experiment certainly was no better than that obtained by the four judges in the first stage of the investigation, and was probably less successful than chance sorting would have been:

DR GOLDMAN-EISLER'S CLASSIFICATION OF 50 CASES
(DU AND CONTROLS)

	DU	CONTROL
Identified	7	9
Misidentified	11	10
Unclassified	8	5

There was, however, one piece of evidence which supported the view that there was a real difference between the groups although it was difficult to detect in individual stories. In the written instructions sent to her, Dr Goldman-Eisler had been asked to write a short description of the main manifest similarities in and differences between the X and Y groups, and to attempt an explanation of these in psychological terms. This was what she wrote:

"The main similarities within group X seemed to me to be an assumption underlying the stories that the relationship between the man and woman who were generally taken to be mother and son, was basically a fond one. The sadness, separation, or whatever trouble was associated with the picture was imagined to be shared by both, and to unite them. The mother-image as conceived by these subjects seems that of the "good mother".

"In contrast the mother-image as emerging from the stories of group Y is much more in the direction of "bad mother" characteristics. The mothers as described by this group disapprove, reproach, or reject their sons. These on the other hand are in opposition and rather more callous towards their mothers

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than the sons of group X. The relationships described are either of open conflict or at best ambivalent.

'Consistent with the two types of mother-son relationship the general mood of group X is more optimistic, while that of group Y is more pessimistic in respect of the future.'

This description of the similarities and differences in the X and Y groups is, of course, based on the stories of the new Criterion Sample of 12 patients and 12 controls. Though similar differences in the attitude to mother recurred in the Remainder, only a minority was identified when Dr Goldman-Eisler applied her definition of the similarities within and differences between the groups.

Independently, and some time previously, the psychologist had attempted to express quite simply his view of the differences he had observed in his original Criterion Sample of 30, of which 8 DU patients but only 4 controls reappeared in the new Criterion Sample. It is remarkable how much agreement there is between the psychologist's (earlier) written account of the differences and Dr Goldman-Eisler's, as the following quotation (from V.K.'s typescript) will show:

'On the whole, in *DU stories* the emotional bond between the young man and the mother-figure is strong and cannot easily be loosened. There is no suggestion that he can find another woman to take her place. Rivalry with another man who has claims on the woman's affection seems to be implied, e.g. in fantasies where another man is removed from the interpersonal relationship or is weakened.

Conflict between the mother-figure and the young man is rarer and weaker than in control stories. The *DU stories* do not in fact express strong aggression either in the relationship of the woman and the young man or in his social behaviour outside it. . . .

'Sometimes there is evidence in *DU stories* that work is associated with anxiety or insecurity.

'In *Control stories*, the emotional bond between the young man and the mother-figure is weaker than in *DU stories*. It can be more easily loosened and can even be severed completely. The young man has sometimes found another woman to take her place. The "other man" who is introduced into some *DU stories* is very seldom found; in contrast with several *DU patients*, it seems, the controls are not so concerned (consciously or unconsciously) about other men who may be rivals for the mother-figure's affection. Conflict between the young man and the mother-figure is more frequent and stronger in control stories. The young man can be openly aggressive to the older woman or she can be so to him. The young man's aggression is not only often expressed in his relationship with the older woman but sometimes in anti-social acts. . . .

Dr Goldman-Eisler and the writer agreed, then, that what distinguished the

stories of the DU patients from those of the controls was a difference in the attitude towards the mother expressed in them. Had the new Criterion Sample not included 12 members of the old one, and had her comments then been similar, this would have been stronger evidence that differences of the sort described were typical.

This experiment was thus inconclusive, but Miss Goldberg on the basis of interview material, much of which describes actual behaviour, concludes that the relationship between mother and son in the DU group tends to be closer than in the control group.

(i) *Speculation on the Relationship between Card 6 Stories and the Oedipus Complex*

The evidence of all this work on Card 6 of Murray's T.A.T. strongly suggests that there is a typical contrast between groups of stories told by DU patients and groups of stories told by controls to Card 6 which is, however, not clear or ubiquitous enough regularly to permit the classification of individual stories with greater than chance success. There is one side of the contrast which is quite objectively scoreable, namely that between the 13 stories by DU patients that contain the 'dying father theme' and the 8 stories by controls on the theme of the 'son undoubtedly marrying'. It seems that both these types of story, when considered from a psycho-analytic viewpoint, express different aspects of the Oedipus complexes of the DU patients and controls respectively. To take the 'dying father' theme first, its Oedipal significance is suggested more strongly by example 2a (page 248) than by any other response. Here the son is 'breaking the news of father's very ill-health or death to the mother. . . . I should say that if it is really the loss of the father there's obviously no psychological problem as far as the son is concerned because he obviously becomes the head of the family'. The DU patient who expressed himself in this way was one of the first tested, and his story was interpreted at the time in terms of his Oedipal wishes to get rid of his father, take his place, and have his mother for himself. His father was actually very much alive. (He was a university student who had been born in another country but his cultural background was not fundamentally dissimilar from that of our main test groups.)

In a statement of working hypotheses issued by the Unit in 1950 we said that the DU patient was 'neurotic'; many patients showed little interest in heterosexual activity; their genital anxieties were related to an unresolved Oedipal conflict, often strongly suggested by the T.A.T. material. It was certainly this kind of T.A.T. story we had in mind at that time, when only a small minority had been tested. This type of T.A.T. response does, indeed, strongly suggest that the childhood wish to be rid of the father and possess the mother is still a powerful force in the storyteller's mind. If we assume for the sake of discussion that our interpretation is right, then our original hypothesis concerning the unresolved Oedipal conflict would be borne out by the evidence; the 'dying father' theme occurred unmistakably in 12 out of 38 stories by DU patients and

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only in 3 out of 36 by controls, which would be statistically significant at quite a high level of confidence on a one-tailed test ($p < .008$).

How was it, then, that the 'dying father' theme (item G) was scored by 3 or 4 judges in 9 DU stories out of 15 in the Criterion Sample but only in 4 out of 23 DU stories in the Remainder (three of these being in the main DU test group)? Close inspection of the stories told, and also of the evidence produced in the 'Inquiry' showed that there were other patients and controls who had this theme in mind but did not come out with it until asked for further information.

Taking the main test groups only,¹ we find that if the evidence of the 'Inquiry' had been included, item G could have been scored as follows:

<i>Criterion Sample (30)</i>		<i>Remainder (32)</i>	
DU	Control	DU	Control
9	2	6	3

So 15 out of 30 DU stories (50 per cent) could then have been scored for the 'dying father' theme but only 3 out of 32 control stories (16 per cent). The assumption that the dying father theme expresses the positive Oedipus complex provides a clue to those stories by control subjects in which the son is undoubtedly going to get married. Those DU storytellers who seem to be expressing the unconscious wish to get rid of father seem also to be simultaneously revealing a strong and enduring emotional attachment to the mother—the childhood wish to possess mother entirely. Those in the control group who state their hero's plain intention to get married, even if mother disapproves, appear to be expressing their determination to find another woman to love who will take the place of mother. The father-rival of the Oedipus complex usually does not make an appearance in these Card 6 stories by the controls about marriage, and it seems as if the young men who told these stories had reached a more satisfactory solution of this universal conflict. It is remarkable that not a single young man with duodenal ulcer spontaneously told a story to Card 6 which could be scored for 'Positive Attitude to Marriage'; only one did so in the 'Inquiry'. These interpretations are quite consistent with Miss Goldberg's observation that the young men with duodenal ulcer tend to have close ties with their mothers.

THE T.A.T. AS A WHOLE

If there are characteristic differences between certain T.A.T. stories of DU patients and controls on Card 6, there should also be some characteristic differences in responses to other cards and, indeed, to the test as a whole, since

¹ Among the Extra Cases item G was scoreable only in the stories of one University DU patient and of a control who was the non-identical twin of another University DU patient and was himself undoubtedly disturbed.

it is unlikely that important psychological conflicts will be projected upon only one picture in a series of fifteen. On the other hand, if the most important conflict concerns the mother it may be more clearly reflected by a drawing usually taken to represent a mother and son. On the whole, the evidence of our investigations, when 15 cards were used and when an objective scoring system was applied, was not inconsistent with the findings when responses to Card 6BM were treated in isolation.

(a) *Selection of Differentiating Features for the Total Test*

The original list of 45 differences observed in the responses to 15 cards in the ratio of 2 : 1 had been expanded after re-analysing the material to include all observed differences. From this second, longer, list 41 items were selected as most likely to discriminate between the records of patients and controls in the Remainder. Criteria for scoring them were defined in much the same way as those for responses to Card 6. To qualify as a feature to be scored an item had to conform to four criteria.

1. It had to seem easily and reliably scoreable.
2. It had to occur in more than two responses in either group in the Criterion Sample.
3. It had to receive a weighted score of at least 3 in Dr Sandler's system.
4. It had to be scored at least twice as often in one group in the Criterion Sample as in the other.

(b) *Attempts at Discrimination by the Writer and by Mr Phillipson*

The psychologist now proceeded to score the complete records of all 74 young men for all 41 items, 8 of which he had already scored in Card 6 responses. The weighted scores for the total test-records were computed in the same way in each case as those for Card 6 responses. It was found that in the Criterion Sample the patients' weighted scores ranged from -5 to +27 and the controls' weighted scores ranged from -18 to -65. Discrimination in the Criterion Sample was perfect. The cutting-point for discriminating between the records of the patients and controls in the Remainder could lie at any point between -5 and -18, and a point midway between these was chosen. When a histogram of the weighted scores of the Remainder was drawn up and -11½ was taken as the cutting-point the discrimination obtained was as follows:

	<i>Remainder : Main Test Groups</i>		<i>Extra Cases</i>	
	DU	Control	DU*	Control
Identified	10	12	6	1
Misidentified	5	5	1	3

* One extra DU record was incomplete and therefore omitted.

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These results fail to reach statistical significance ($.10 > p > .05$), but would do so on a one-tail test. The discrimination is more accurate than that obtained by V.K.'s scoring of Card 6 responses. Looking at the extremes we find 6 controls with scores between -18 and -35 and only 3 patients; and 5 patients with scores between -5 and $+27$ but also 4 controls (one of whom had received a score of 0 for a very meagre record). The score of $+27$ was obtained by a DU patient and that of -35 by a control. Interestingly enough, in the records representing the poles, the dying-father theme occurred in the Card 6 response of the DU patient and the marriage theme in that of the control!

The records of the remaining young men in the main test groups and of two extra controls were also scored by Mr Phillipson after all marks of identification had been removed. As he did not score the records of the Criterion Sample (except for Card 6 stories) the cutting-point derived from V.K.'s scoring was applied to H.P.'s with the following results:

	Remainder : Main Test Groups		Extra Cases
	DU	Control	Control
Identified	10	9	1
Misidentified	5	8	1

This discrimination is on the whole less successful than V.K.'s. At the very extremes, however, it is clearer, since there are 3 controls and 4 DU patients at or closest to the appropriate poles. The largest DU score of $+16$ was given by H.P. to the record that had received the score of $+27$ from V.K. His largest control score of -30 went to the record with the score of -35 awarded by V.K.¹

The reliability of the scoring varied from feature to feature as in Card 6. Discrimination of the remaining 32 cases in the main test groups and 2 extra controls was attempted, counting only those features which had been scored by both H.P. and V.K. and taking $-11\frac{1}{2}$ as the cutting-point. The results were as follows:

¹ The most striking feature of the contrast between these 'polar' records is the much greater amount of aggression in that of the control than in that of the DU patient. Of the control's 15 stories no less than 10 deal with killing, usually of a criminal kind, but killing occurs in only one of the DU patient's stories and it is involuntary—a man kills his wife in a 'mental blackout' and escapes the death penalty. Apparently the patient could not express aggression in fantasy with anything like the ease of the control; he said the dying father of his Card 6 story would recover and on Card 11 imagined a dragon whom it was taboo to kill.

The patient appeared to be more concerned with, and dependent on, both father and mother, and, unlike the control, introduced them both in disciplinary roles. (He was, however, considerably younger than the control.)

	Remaining Cases in the Main Test Groups		Extra Cases
	DU	Control	Control
Identified	11	8	6
Misidentified	4	9	2

When our joint scoring was used, the same DU and control records (with scores of +21 and -30 respectively) were found at the poles as when the individual scoring of each of us had been used. Between -18 and -30, however, there were now 3 controls and 2 patients; between -5 and -21 there were now 5 patients and 4 controls.

(c) *Validity of our Scoring System for the Total Test*

Our scoring system, though fairly reliable, was certainly *not* valid when applied to the total test. Of the 41 items selected from the Criterion Sample material as likely to differentiate DU patients from controls in the Remainder, the trends of 13 were actually reversed in the Remainder and there was no difference between the groups in respect of 7 further items. Only 21 items, little more than half, showed the same trends in the Remainder as had been revealed in the Criterion Sample, but the ratios were usually found to have changed (V.K.'s scoring). It is obvious that the excellent discrimination obtained by the psychologist in the Criterion Sample, when the complete T.A.T. records were used, was the result of including many chance factors in the list of features to be scored.

In spite of the poor validity of the scoring system when applied to the total test, there is some tendency for the appropriate people to appear at and near the poles. This suggests that in addition to measuring a number of variables in respect of which the duodenal ulcer patients and the ordinary 'young men' do not typically differ, the T.A.T. as scored by the writer is also measuring along a dimension in respect of which these groups really do differ. Only by the investigation of new groups, or a fresh analysis of our T.A.T. material in terms of a different scoring system known to be both reliable and valid, can we hope to attain certainty on this point.

PROVISIONAL CONCLUSIONS FROM THE PSYCHOLOGICAL
INVESTIGATIONS

Young men with duodenal ulcer tend to reveal a larger degree of general neuroticism than other young men, and this seems to be only in part explicable as a consequence of their illness. In a proportion of cases the degree of neuroticism shown is fairly high and may have been a relevant factor in the aetiology of the disease. Young men with duodenal ulcer show some tendency to be introverted, inhibited, and socialized rather than extraverted, uninhibited, and asocial. They are apparently, on the whole, more self-controlled and conven-

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tional and less tolerant of tension than other young men. There is some evidence from psychological tests that 'neuroticism' in young DU patients is associated with a close emotional attachment to the mother and hostility, probably unconscious, to the father. It would be wrong to conclude from these psychological test findings that *all* young DU patients are neurotic or introverted or emotionally dependent on their mothers. The DU group contained some who had low neuroticism scores on the M.M.Q., some with extratensive personality profiles on the Rorschach, and some who were repeatedly classed as controls on the T.A.T.

The psychological investigations reported here did not reveal anything specific in the psychopathology of duodenal ulcer that would exclude the possibility of psychoneurotic or other 'psychosomatic' symptoms, but they cannot, of course, be taken as disproving theories of emotional specificity based on other kinds of evidence. As far as they go, our psychological findings suggest that when young men with duodenal ulcer are neurotic, they are more likely to be controlled 'dysthymics' than uncontrolled 'hysteries', but that they have the same central psychological conflict as other neurotic young men.

Our work on Card 6 of the T.A.T. suggests that the young DU patients tend to be dependent on a good mother rather than in conflict with a bad one, and therefore appears to be more consistent with Alexander's theory than with Garma's, but their complete T.A.T.'s often reveal ambivalence to the mother.

It may be that in those cases of duodenal ulcer in which there is little evidence of neurotic disorder it is the stress of adverse circumstances that has had the same effects as the stress of inner conflict. The type of reaction to stress must partly depend on the constitution on which it falls, and modern research in physiology and genetics has established beyond doubt the importance of constitutional factors in duodenal ulcer.

In evaluating these findings, the fact that the control group included a number of young men with dyspepsia and neurotic disorders should not be forgotten. The samples were small. The results of statistical tests of significance should be treated with caution as a great many comparisons were made. *These conclusions are, therefore, provisional and await confirmation or disproof in further research.*

Our experience shows that well-designed questionnaires such as the M.M.Q. and Tavistock Self-Assessment Inventory are likely to prove useful for preliminary classification of the subjects. The Rorschach, however valuable it may be in the clinical situation, appears unlikely to elucidate the problem of duodenal ulcer further unless scoring methods more relevant and statistical tests more sensitive replace those which are generally used. Murray's Thematic Apperception Test has, however, once more revealed itself as a promising approach to the study of psychosomatic illness. The mother-son card (6 BM) could easily be used on large numbers of DU patients and might enable us to carry out a con-

clusive test of the hypothesis that they tend to be more mother-dependent in fantasy than other men.

A longer, more detailed and technical account of these psychological investigations may be obtained by those professionally interested in such research from the publishers.

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APPENDIX II

Short Case Summaries of Ten Mothers in the DU Sample and Eleven Mothers in the Control Sample rated as having Neurotic Traits

Mothers in the DU Sample

Mrs Baxter (DU 20) used to wet the bed until she was 13. She frequently attended hospital with aches and pains and complained of excessive tiredness. The physician was unable to find any organic cause and ascribed the condition to emotional and domestic stress. This woman married a foreigner whom she described as excessively immature and dependent on her, and very jealous of any attention she gave to the sons. She resented his infantile dependence, and appeared to escape from her marital problems into friendships with women and socially congenial work, which took her away from home in the evenings when her husband was about.

Mrs Bennett (DU 15) always seemed on edge, an unhappy woman who was quarrelsome, nagging, and very obsessional. She described herself as nervy, hated being alone, and had had many fears as a child. She was greatly attached to her mother, whom she described as 'a perfect woman' and talked about her recent death as a disastrous blow with which she seemed unable to cope. She appeared to withdraw from her family by working as a cook at a night canteen, which took her away in the evenings.

Mrs Booth (DU 14) was a restless person, always on the go, who nagged and drove her only child, about whom she felt deeply guilty. She was frigid and had unsatisfactory sexual and emotional relationships with two husbands. Her own mother she described as a wonderful woman and mother. Her father was unstable; at times he ran a successful business, earning a great deal of money and doing all he could for his family; these phases alternated with periods when he went off with other women, drank, and did no work at all. The maternal grandmother eventually left him. Mrs Booth's feelings for her father were not entirely negative. She gave him full credit for his good points, and she attended his funeral. She left her first husband when her son was a year old without any obvious external reason. She enjoyed the ensuing years of freedom, providing ample financial support for her mother who actually brought up the child. After fifteen years she remarried, and

had to face several crises in her marital life and in her relationship to her DU son during her contact with the Unit. She regretted her loss of freedom and had again come up against her dislike of any sexual relationship. She had pronounced sadistic attitudes towards a tiresome senile mother-in-law, while admiring her own mother, of whom she had only good things to say.

Mrs Brown, one of our three typical examples, complained of anxiety attacks and palpitations; she was grossly obsessional and felt compelled to follow a tight schedule. Her son said she was continually 'running around, dusting and putting things away'. She was a very poor sleeper, and frequently became dissatisfied and depressed. Her story was that of a resentful Cinderella who submitted to the demands of a forceful mother and more attractive sisters, but who idealized her father. She had severe conflicts over her aggression and her desire to drive people, which made her feel unlovable.

Mrs Dale (DU 18), who was not seen herself, was described by her husband and son as a quarrelsome, unstable person who had phases of hostility and paranoid suspicions when she used to become physically violent, especially towards her husband. Her symptoms increased considerably during the menopause. Labouring under the delusion that he was not her own child, she completely rejected her son and treated him with inhuman severity.

Mrs Ellis (DU 19) stated that 'cleanliness was the most important thing in life'. She was frigid and breast feeding caused her disgust and embarrassment. She had a pronounced fear of running water and doctors, and could not bring herself to go on any doctor's panel. Her fear of doctors was associated with an episode in her childhood when a doctor cut off her mother's long and beautiful hair. She was very attached to her father who was described as a successful farmer, strict but kindly, youthful up to a ripe old age, whereas her mother was an invalid for many years.

Mrs Fry (DU 16) 'goes the trembles' when upset. She related many fears of spiders, the dark, the lavatory, throughout childhood and adolescence. Her sister described her as the most nervous one in the family. She was grossly over-anxious and over-protective with her children; she could not bear to see anything untidy. She came of a very large family and felt that she had never had any privacy in her overcrowded home. She married in order to get away from home without feeling any deep love for her husband. The maternal grandmother was described by Mrs Fry's sister as an over-protective 'broody hen' who was unable to let her children go, and it looked as though Mrs Fry was repeating this pattern.

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Mrs Fuller (DU 17) had been suffering with her 'nerves' since the death of her mother, which precipitated a breakdown. Her hands, lips, and eyes began to tremble when she was upset. Psychological treatment was recommended some years ago but not carried out. She easily got into a panic and her children did not quite know where they were with her. Her father died when she was a child and she preserved a close attachment to her mother, sharing a house with her during the first years of her married life.

Mrs Gilbert (DU 3) had severe physical handicaps in the form of very bad eyesight and hearing. As a child she suffered from a skin complaint on her head which necessitated all her hair being cut off, and wearing a cap which made her the laughing-stock of other children. All her life she had felt different from other people and isolated. As a child she used to hide for hours in order to get away from everybody. She was terrified of, and hostile towards, a drunken father who, she said, singled her out for attacks. She was closely attached to and dependent on her mother, in whom she confided throughout her life and who helped her in bringing up her children. Mrs Gilbert was a depressed, odd-looking woman who felt unappreciated and unloved. She found it difficult to establish a warm relationship with her children or her husband, and had to 'keep going', as otherwise she would become 'miserable'. She was a poor home-maker and was acutely aware of the criticism of her children who found her a very unsatisfactory and ineffective mother and housekeeper.

Mrs Harris (DU 13) described herself as a 'nervous wreck'. She was severely obsessional, her sleep was disturbed, she was highly emotional and irritable and drove herself and her children relentlessly. There was a strong sadistic quality in her dealings with her children. She had some functional eye trouble which she herself interpreted as resulting from a suppressed need to cry. She idealized both her parents, who were described as prototypes of goodness, generosity, and wisdom and who seemed to be the sources of high ideals in this woman. She married a man who turned out to be sexually perverse and promiscuous, severely paranoid, and unstable in his work. After thirty-five years of a very unhappy marriage, which her strong religious convictions forbade her to dissolve, she finally left her husband. She reported that she had been a perfectly ordinary happy girl in her youth, and that she had become progressively more ill during the intolerable stress of her marriage.

Mothers in the Control Sample

Mrs Bailey (C 4) was a highly unstable, quarrelsome woman, a trouble-maker who continually had rows with her neighbours, and thought that people were talking about her. She had attended her doctor for 'nerves'.

She disliked her husband intensely, and declared that she was not fond of children, although she was the mother of five. She had had a hard childhood, during which she felt unloved and neglected. She had had an illegitimate child, married the father under pressure, and was separated from him for five years soon after marriage. She was a poor home-maker and a most unhappy woman. The general practitioner and the P.S.W. felt that this woman's interpersonal relations were so deeply disturbed that she might well become psychotic at a later stage.

Mrs Bartlett (C 10) said that she had always been a worrier. She became easily depressed. Recently she had developed a fear of crossing the roads and she lacked confidence generally. Her symptoms had increased after her menopause and since there had been an indefinite threat of a possible operation for gall-bladder trouble. She felt that she was very much like her mother who had been a very nervous woman with a severe tic. Mrs Bartlett had experienced a great deal of stress recently; her husband had become a serious invalid and her daughter's family had developed TB.

Mrs Bradshaw (C 7) described herself as a worrier; she was a poor sleeper and had pronounced masochistic tendencies. She wore herself out waiting on a neurotic husband. She neglected her health, she was frigid and was obsessively clean. Her mother died in childhood and she looked after her father, a highly intelligent, enterprising man who dominated her life completely, and who expected her to devote her life to him. She married an intellectually inferior, dependent husband at a comparatively late age but continued to 'put her father first'. Later she waited on her husband in the same manner as she used to wait on her father. At the same time she identified herself with her father in being the man about the house, doing plastering and decorating and making all the decisions.

Mrs Brewer (C 9) suffered with vague headaches. She frequently consulted doctors and became easily depressed. She had strong tendencies to hoard and recently had become absorbed in excessive housework. She found it difficult to make friends, and was of a discontented nature. Following appendicectomy she complained of pain in her upper abdomen and after investigation her symptoms were thought to be functional in origin. The background of this woman's neurosis has remained obscure. Her mother, like herself, used to have headaches; she appeared to have had a happy but very protected childhood. She married a highly intelligent, optimistic, and easy-going man whom she likened to her father.

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Mrs Briggs (C 12) reacted to a grim reality situation of a permanently sick husband with compulsive over-work and many manifestations of masochism. She seriously neglected her own health; she betrayed an almost conscious desire to destroy herself, and showed great antagonism to any helpful acts by doctors. She confessed to a complete inability to express tender feelings to husband and children. She was one of 17 siblings and let herself be grossly exploited in domestic service before drifting into marriage in order to make room at home. Her continual child-nursing duties in her parental home had evoked a strong dislike of babies that she later compensated for in possessive and over-protective behaviour with her own children. Her method of coping with an almost unbearable reality situation was flight into work and an obstinate fight for independence.

Mrs Chambers (C 13) was sent to hospital for fibrositic pains in her shoulders, back, and arms, and the provisional diagnosis made was osteo-arthritis of the cervical spine with secondary minor root lesions. She attended the physiotherapy department, but did not do well. She developed pains in other joints and the doctor decided to discontinue physiotherapy as he considered that there was a very large functional element in her complaints. She had experienced great difficulties in her relationship to her mother, who was described as a severe hysteric and who had rejected this daughter. Mrs Chambers married a very dependent husband who had been dominated by his mother. Mrs Chambers, an independent and intelligent woman, took up the struggle with this mother-in-law. At the same time she formed a strong positive relationship with a landlady who became the good mother figure, and Mrs Chambers often wished that she should have been her mother. The exacerbation of her pains and attendance for physiotherapy coincided with the death of this good mother-figure. Mrs Chambers felt that everything was on top of her, and that she could not manage her work on account of the pains, but was not aware of undue depression, nor had she ever linked the two events. Another illuminating feature was that during this time she became negative towards the P.S.W., in whom she had confided at great length in previous sessions. Her negative feelings were aroused by the P.S.W. asking her to complete a questionnaire on the upbringing of children. The mother felt that this demand was taxing her too much and that she could not comply with it. The P.S.W.'s request may have appeared reminiscent of her childhood situation when she had felt that her mother was continually demanding work from her, in contrast to the boys who were allowed to enjoy themselves, and it is possible that the loss of the good mother-figure made her feel that there were only 'bad mothers' left.

Mrs Cooper (C 5) had a fear of crowds, did not go out on her own and suffered from palpitations. She was preoccupied with a vaginal discharge,

and other sexual matters. Before World War II she had had a nervous breakdown during which she felt depressed and things became too much for her. In the past psychiatric treatment had been recommended but not carried out. She described her father as quarrelsome, inconsiderate, and drunken and her mother as lovable and kind. She clearly remembered the anxiety she experienced when left alone at home while her parents went out. She had married a greengrocer and they lived over the shop. Her husband was an extremely jealous man and her symptoms appeared to fulfil his need to have his wife close by him and not in contact with other men.

Mrs Cox (C 8) was a nervous woman who had fears of the dark, doctors, and hospitals. Her life centred mainly on cleaning and strict routine. She had strong anal preoccupations. Her father died when she was about 3 or 4 and she felt guilty about not being able to remember him. He was a ne'er-do-well. She idealized her mother who had been phobic and asthmatic. Mrs Cox and her family used to live in her mother's house, and Mrs Cox used to do all the housework for her. She appeared to blame herself in some way for her mother's death, which occurred a few days after Mrs Cox and her family had moved away. The old lady's memory is preserved by regular flower tributes and memorials in the local paper.

Mrs Dobson (C 6) described herself as a 'worrier' and was a poor sleeper. She attended hospital for headaches, which were considered to be functional in origin. She was married to an alcoholic husband to whom she was devoted. She used to suffer from an uncontrollable temper which led her to beat her children unmercifully. She was very impatient and had poor interpersonal relationships. Her own father was a drunkard of uncertain temper. Her mother, to whom she was very attached, was described as someone who would help anyone in trouble, and who throughout her difficult marriage, was a support to her.

Mrs Hammond (C 11) was over-anxious about health problems; she frequently consulted the doctor who reported that she over-reacted to every situation and was in a chronic state of 'twit'. She appeared to have considerable doubt about her qualities as a good mother and had a need to impress on the P.S.W. what a successful and good mother she had been. She idealized her own mother, who was described as an 'angel' and whose death had caused great distress, and she described her father, who was a drunkard, as a 'devil'.

Mrs Hodges (C 2) was a highly-strung, hyper-active woman who combined a full-time job with running a home and private dressmaking in the even-

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ings. Up to her menopause she used to be well for nine months in a year, and unwell for the rest. Her symptoms consisted of very bad headaches, and a feeling of being run down generally. Her husband used to nurse her. She also suffered from what she called rheumatics in her arms. These pains cleared up dramatically within twenty-four hours of the removal of her teeth. Mrs Hodges had never been able to make friends easily. She lost her father in infancy and felt herself severely rejected by her mother, who preferred her younger brother. She had to work hard while her mother and brother went out; her hyper-activity appeared to be due to a compulsive need to gain approval, originally, from the maternal grandmother.

APPENDIX III

The Uncooperative Families in the Control Sample

Questions worth exploring, not only in connection with this study but also to throw some light on the general problem of cooperation, are: Who are the people who fail to cooperate in this type of intensive investigation? Have they any common characteristics, and what may be the reasons for their non-cooperation?

Table 1
COMPOSITION OF THE SAMPLES

	<i>DU</i>	<i>Control</i>
All approached	36	73
Less—not available (Forces, moved away, informant inaccessible)	—	22
Less—Uncooperative	1	17
Less—cases investigated but excluded because information insufficient	3	2
	<hr/>	<hr/>
Included in present series	32	32

Table I shows that out of 73 people contacted, 22 were inaccessible for reasons outside the investigators' control: the young man was in the Forces, or the family had moved away, or the mother was for some reason or other not available. On obtaining such information the families were not asked to participate in the study. The families that are of interest in this discussion are those who either refused to cooperate or 'lapsed' after a short while. There were 17 of these. The first 7 are of particular interest as they belong to the original random sample and any information available about them will indicate in what way the sample was biased. From a more general point of view of exploring the characteristics of 'non-cooperative' families, the remaining 10 replacements are of equal interest; and for this reason these 17 families will be considered together.

The first general impression gained was that these families were of lower social status than the cooperative ones; that on interview they appeared to include more people with low intelligence, and that a higher proportion lived under very poor material conditions. It was possible to ascertain the type of employment of 14 fathers. Nine of the 14—over half—belonged to Social

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Classes IV and V (semi-skilled and unskilled labour), whereas of the 32 controls who cooperated there were 9 in these categories.

Apart from the social class difference, this group of families also seemed to contain a larger proportion of individuals with social and psychological problems than the families who cooperated. A more detailed scrutiny of the possible reasons for non-cooperation confirms this impression.

Table 2 ASSESSMENT OF THE POSSIBLE UNDERLYING REASONS FOR NON-COOPERATION OF 17 FAMILIES IN THE CONTROL SAMPLE

	1st 7	The rest	Total
1. Very low intelligence and economic status	1	2	3
2. Serious problems in the family	2	2	4
3. Subject emotionally disturbed	1	3	4
4. Subject and/or family pre-occupied with own affairs, not interested	2	1	3
5. Work reasons	—	1	1
6. Reasons very unclear	1	1	2
Total	7	10	17

This table shows that the reasons for non-cooperation and their distribution are similar among the first 7 families and the rest and I shall therefore not distinguish between these two categories in the following discussion. First there were 3 families who were so limited in intelligence and lived in such overcrowded and dilapidated conditions that effective cooperation seemed impossible. They always kept the P.S.W. on the doorstep and seemed deeply suspicious about her intentions. Possibly they felt too inferior and too aware of their social failure to allow a stranger to inquire into their disorganized ways of living, particularly when apparently nothing was offered in return. In one case these feelings were cloaked by a very aggressive attitude to the P.S.W. It is interesting to speculate whether any of these families would have made an attempt to cooperate if remuneration had been offered. None of the cooperating families showed similar low standards of intelligence and social effectiveness.

Another 4 families appeared to have serious problems with which they were preoccupied. The puzzling contradiction in these cases is that all these families revealed their problems during the first interview and seemed to ask for help, yet they withdrew later and seemed unable to make use of the therapeutic opportunities offered to them. Mrs A. who interviewed the P.S.W. on a dark doorstep for almost an hour, had to be reassured repeatedly that the investigation was not concerned with physical experiments. She soon discussed the problems of her younger son—the brother of our control subject—who was very jealous of his more successful brother and who had been unable to settle down

at school or at work, refusing to get up in the morning and to work altogether. The mother felt that he was in need of psychiatric help and he sounded as though he was on the border line of psychosis. During the visit a stepfather appeared who seemed of very low intelligence and who talked in a threatening, wildly suspicious, and incoherent manner and conveyed an impression of being mentally ill. The subject, aged 17, was the bright boy of the family and the pride of his mother. He was mature in his attitude and seemed willing to co-operate. During the second visit the mentally sick brother had been induced to stay in so that the P.S.W. could see him and it was agreed that the Unit team would try to help in sorting out his problems. Although the mother was still somewhat suspicious of the P.S.W.'s motives, everything seemed set for a reciprocal relationship in which the bright brother would help the research team and the team would in turn help the family with the sick adolescent. However, the subject failed repeatedly to keep his appointments and the P.S.W. was able to see the mother only once more. It is possible that the father finally succeeded in putting his foot down, as he adhered to the view that the investigation was a dangerous experiment. On the other hand, it is possible that the mother felt unable to face the many painful problems that were going to arise in our discussions. It was evident from the three visits that she had in some ways rejected the sick boy, that she now felt guilty and in part responsible for his trouble, and that she also felt hostility towards him for not working and making inordinate demands on her regarding food, pocket money, and time.

In another family the subject himself had suffered from severe neurotic difficulties since childhood. Both he and his mother in their respective interviews seemed relieved to meet helpful understanding at last. Yet neither of them was able to continue the contact with the Unit. As in most of the other uncooperative families, there was a good external reason for this: the mother had taken up full-time work. But there were also indications, from hints about a difficult father and other family problems, that, as the general practitioner put it, 'they did not want to let any skeletons out of the cupboard'. Thus, again, the desire for treatment was checked by stronger forces militating against it. In the third family the contact never extended beyond visits to the subject and his wife, as the parents lived in a different area. On the first visit he and his wife talked with great frankness and at length about their marital problems. They both revealed much insight into the forces that were creating conflicts between them and seemed eager for further opportunities to talk. The young man kept his first appointment at the Unit and clearly found satisfaction and relief in his interview with the psychiatrist. He arrived 45 minutes late for the second interview and then terminated the contact explaining that his work made it impossible for him to attend. Previously the G.P. had had similar difficulties in obtaining the young man's cooperation to have X-rays after repeated attacks of 'pleurisy'. His argument was the same, 'I am a very busy man.'

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In the fourth family the situation was not quite as clear. The mother in this family replied to the P.S.W.'s letter asking for an appointment by writing right across it: 'not interested whatsoever'. The young man saw the psychiatrist once, when he revealed a very unsettled work history and a forced marriage at the age of 18. The G.P. described the young man's son as an unhappy and aggressive child whom he had referred to a child guidance clinic as much for parental guidance as for the boy's benefit. (It should be noted that referral to a child guidance clinic is a very rare occurrence in this doctor's practice.)

It is of interest that these four families with the possible exception of Mr Blake (C3, p. 122) presented the most explicit psychological problems in the whole of the control sample for which the kind of help that could be given by a team of psychiatrist, psychologist, and P.S.W. seemed most appropriate. Yet, although these families felt in need of help and were able to formulate their problems, they were unable to avail themselves of the opportunities offered. Possibly they had not arrived at a point where their need was so painful that treatment *had* to be sought, whatever the cost in terms of energy, time, and painful revelation. Another difficulty may have arisen. These families may have found themselves in a false role to start with. The team was asking for their cooperation as controls—presumed healthy—to a sick population. In order to fulfil this role, the families needed to feel a certain confidence in their own health and in their ability to help the research team. Their own sickness, however, forced them to turn the tables immediately and the clinical background of the research workers caused them in turn to respond—perhaps too readily—to the therapeutic demands; this may have confused the issue intolerably. It is true that among the cooperative families unmet therapeutic needs also came to the surface, and a certain amount of 'treatment' ensued, but the roles were adapted gradually and the need for help hardly ever appeared in the form of a direct or urgent demand.

Similar forces may have been at work in the cases of four young men who refused cooperation straight away, mainly for work reasons. All four showed signs of considerable emotional disturbance. In three of these families the parents also suffered from nervous complaints. The mother of the first young man was found to suffer with very severe psoriasis. She pointed out that 'this was nerves' and she was anxious to cooperate, particularly if it entailed help for her. Her son was married and living in a different district. He angrily refused to assist in the investigation, saying that he had done his bit in the Navy where he was wounded twice. He felt very resentful towards hospitals and thought that the investigation was an imposition. His hostility was so intense and out of proportion to the actual demands of the situation that deeper forces must have been at work. Another young man was friendly in his attitude, but was unable to give the time because he was working in distant areas, uncertain at what time he could be free; in addition he was very busy courting. He mentioned that he

was away from school a good deal with bilious attacks and temperatures from which he still suffered, that he was subject to giddiness and headaches, and that he fainted easily. He had been rejected for military service. He said that his sister was worse and concluded that their trouble was hereditary, as his parents were first cousins and nervous. He indicated that he had learned to live with his symptoms. In this case there were good external reasons for non-cooperation. However, internal forces may also have been at work warning him against the risk of opening up his problems and constituting a protective device to keep his defences intact. Another young boy of 16 was seen in the presence of his mother. He did not look at the P.S.W., was unfriendly and remote, with a pale and unhappy appearance, and said that he did not want to help and was not interested. The mother indicated that she would be willing to cooperate in the inquiry and that this boy was a problem to her because of his moodiness, which at times led him to be silent for days. Again the team had to respect the refusal of this youngster although he was clearly a disturbed and unhappy person. The fourth boy was the younger brother of Briggs (C 12). He was too frightened to attend the Unit. He was unable to go out by himself, or to take a job away from home and could only manage to work with his mother in the small factory where she was a forewoman. His family background was a difficult and disturbed one, but his parents were willing to cooperate, possibly because the father, a chronic invalid, had been a patient at the hospital for many years. When his older brother, who was a highly intelligent and conscientious young man, turned up in the sample, no difficulty was experienced in obtaining his and his family's cooperation.

There were three families who seemed to be so involved in their own affairs that they had no time or inclination to become interested in the research. One young man had recently got married; a very young father of two children was working a great deal of overtime and had previously helped in a survey of eighteen-year-olds carried out by a doctor in the same Unit. There was a big, happy, but somewhat disorganized family in which many crises occurred and where the mother, though friendly, seemed unable to keep appointments. However, in this family the causes for non-cooperation may have been deeper. The children were often at home when they should have been at school and none of them seemed particularly truthful. The G.P. said that the father was a fairly severe hypochondriac.

In two families the reasons for non-cooperation remained completely obscure. From both, the initial visit met with a friendly response and no obvious problems were revealed, but in one case the son, and in the other the parents, failed to cooperate and were determined to avoid further contacts.

Finally one young man was working far afield in the building trade and had real difficulty in keeping any appointments, although he always promised that he would turn up. Even here, where the reality situation was the most impor-

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tant factor, less obvious resistances that were not confined to his attitude to the research seemed to play a part. Previously he had been admitted to hospital with a T.B. effusion, but he took his own discharge, and refused further investigation or follow-up. The G.P. described the family as a completely asocial one, who were shunned by their neighbours.

Summary and Conclusions

Surveying the group of uncooperative families, it was noticed that they were of lower social status than the families in the control sample who cooperated in the research. Eleven of the seventeen families seemed severely disabled either socially or psychologically, which is a much higher proportion than in the cooperative families.¹ Almost half the families were struggling with considerable problems for which they did not wish to ask for help or which could not be dealt with in the context of this investigation, which put the client in the role of helper rather than patient—at any rate in the initial phase. In a comparatively small proportion of the families, practical reasons were sufficiently strong to account for their inability to participate, and in at least two families the reasons for their non-cooperation have remained obscure. The families whose psychological and social handicaps played a part in their non-cooperation seemed to fall into three groups: first, those who shut their doors firmly to the inquiring stranger in an attempt to hide their problems and inadequacies from the outside world and possibly also from their own consciousness. Second, those who were undecided whether to open their doors or not. On the one hand these people recognized their problems and would have liked help, on the other they seemed unable to tolerate the pain of facing their difficulties. Third, there were those who either had learned to live fairly comfortably with their troubles or needed their symptoms for their adjustment, and who may have refused to cooperate in order to keep their defences intact.

One might draw the tentative conclusion that a certain level of adequacy and social competence is necessary for individuals to tolerate an investigation that asks a good deal from them and offers uncertain returns. Families also appear to need a certain amount of confidence in their own health or 'goodness' and ability to cope with life reasonably well before they can entrust their experiences to the scrutiny of a stranger, however understanding. Exceptions may be cases in which needs are so desperate that people will clutch at any straw in order to get help.

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¹ This observation fits in remarkably well with that of Cochrane (1951) who showed that those people who were the last to come up in a chest X-ray survey had far more clinically significant tuberculosis than those who cooperated straight away.

APPENDIX IV

Peptic Ulcer and Dyspepsia in Young Men brought up in Dr. Barnardo's Homes

WRITTEN IN COLLABORATION WITH C. F. STEVENS

Aim of Inquiry

This small survey was started before any results were available from the main clinical investigation reported in this book and was based on the following hypothesis: if duodenal ulcer is related to psychological disturbance, and if this is in turn related to a disturbed family background, then young men who experience severe disruption in their early family life (such as those admitted to Barnardo's do) are more likely than the general population to have an ulcer or chronic dyspepsia. It was further postulated that duodenal ulcer or dyspepsia would be more than normally common among these young men who had suffered prolonged separation from the mother in early childhood. The object therefore was two-fold: to inquire whether ulcers are more common among ex-Barnardo boys than among other young men of the same age; and to see whether there is any relationship between the prevalence of duodenal ulcer among the young men and the different reasons for which they were admitted to the Homes—in particular whether separation from the mother was highly associated with the subsequent development of an ulcer.

Method

In order to compare results with the main inquiry, this survey was restricted to young men who had left Barnardo's and were under the age of 25. Of the 3,000 young men in this age range, no present addresses were available for more than a third, which puts a serious limitation on the validity of any results obtained. A questionnaire asking for details of any present or previous 'stomach trouble', including symptoms, diagnosis, and treatment, was sent by the executive officer of Dr Barnardo's Homes to each of the 1,779 young men for whom addresses were available, with a covering letter explaining the reasons for the inquiry and assuring the young men of its confidential nature. The investigators had no knowledge of the young man's name or identity, the form being identified by a number given to each boy. However, the Barnardo authorities provided three items of information about each of the 1,779 boys (using their numbers); the

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date of the boy's birth and of his admission to the Home, and the reason for his admission. A list of factors affecting the case for admission was worked out by the investigators in conjunction with Dr Barnardo's staff as follows:

1. Loss of father
2. Loss of mother
3. Loss of both parents
4. Ill health of parents
5. Parents unmarried
6. Neglect (care and protection, custody order, N.S.P.C.C., etc.)
7. Desertion by either parent, or separation of parents
8. Behaviour problems (beyond control, etc.)
9. Poverty
10. Admitted for sea training.

Most boys fall into more than one category and in these cases each category was counted and given equal importance. This procedure seemed to be safer, having regard to the multiplicity of causes that usually led to a boy's admission.

The information relating to the existence of gastric disorder was grouped under three headings according to the following criteria:

1. *Ulcer (U)*—an affirmative answer to the question whether the subject had been told that he had any of these illnesses: stomach ulcer, gastric ulcer, duodenal ulcer, peptic ulcer, perforated ulcer, any other ulcer.
2. *Chronic Dyspepsia (CD)*—an affirmative answer to the question whether the subject suffered from attacks of indigestion or pains in the stomach lasting three days or more, provided that he had had six or more attacks, 'regular' attacks, 'many' attacks, or 'frequent' attacks in the last two years.
3. *Mild Chronic Dyspepsia (MCD)*—an affirmative answer to the question about indigestion with 3, 4, or 5 attacks in the last two years.

The ratings were of course carried out without knowledge of the boy's reason for admission to Barnardo's (indeed most of them were made before the 'reasons' for admission were notified to the Unit). On the basis of the medical information available from the questionnaire and of the information supplied by Barnardo's on the reason for admission, we could determine the prevalence of ulcer, chronic dyspepsia, and mild chronic dyspepsia, as above defined, among those who replied; and possible relationships between the reasons for admission and such disorder could be sought. It will be evident that this questionnaire method could not ascertain the site of the ulcer (i.e. gastric or duodenal) whereas in our main study we were dealing exclusively with duodenal ulcers. However, as the occurrence of a gastric ulcer is extremely rare in young men under twenty-five, it is reasonably safe to assume that almost all the 'ulcers' reported among the Barnardo young men were in fact duodenal (if they were ulcers at

all), and hence the results of this study can be compared with those in our main study.

Response in Relation to Age and Reason for Admission

Eight hundred and seventy-nine replies were received in response to the first letter, and reminders brought a further 171 replies, making a total of 1,050 replies out of the 1,779 sent, or 59 per cent.

Among boys admitted for the 10 different reasons mentioned above the responses varied only between 53 per cent and 65 per cent (except for the few admitted for sea training). Analyses of the reasons for admission for the boys who replied spontaneously, after a reminder, and not at all, showed that the boys who did reply were representative of all those to whom the questionnaire was sent.

As might have been expected the response rate was higher among the under-twenties, both among the first 979 replies and the later 171.

Results

1. *Prevalence of Ulcer.* There were thirteen young men who were considered to have or have had an ulcer. The number that would be expected in the same number of men of this age if they had been subject to the rates found by Doll and Avery Jones (1951) is 13.2. The observed prevalence of ulcer among these ex-Barnardo boys is, therefore, consistent with the only other known rate for this country. Hence there is no evidence to support the original hypothesis that ex-Barnardo boys suffer more frequently from peptic ulcers than the general population. This result is consistent both with Kellock's findings (1951) and those of our main study reported in this book, namely that death, 'separation', divorce, and 'broken homes' generally are no more characteristic of the background of patients with a duodenal ulcer than of 'controls'.

2. *Relation of ulcer and dyspepsia to reason for admission.* Table 1,A shows the number of young men in each category who were observed to have an ulcer, chronic dyspepsia, or mild dyspepsia,¹ compared with the number that would be expected if the reasons for admission of the young men with an ulcer or dyspepsia had been distributed in the same way as for all the young men who returned a completed form. Table 1,B shows those reasons for admission in which the number observed is consistently greater than, or consistently less than, the number expected for all three forms of dyspepsia. We notice five consistent agreements though many of the differences are very small: ulcer is more common and there is more dyspepsia than expected where the boy had been admitted because he lost his father (Cat. 1) or where poverty was a reason (Cat. 9). Ulcer is less common and there is less dyspepsia where the boy had

¹ Each young man has only been included under one form of disorder—the most severe form of dyspepsia mentioned on the form.

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Table I
NUMBER OF YOUNG MEN WITH AN ULCER OR DYSPEPSIA
COMPARISON OF OBSERVED WITH EXPECTED NUMBERS ACCORDING TO REASON FOR ADMISSION

	A				B		C		
	Young Men with								
	Ulcer		Chronic Dyspepsia		Mild Chronic Dyspepsia		Sign of Difference (Obs-Exp)		U or CD or MCD
	Observed	Expected*	Observed	Expected*	Observed	Expected*	U	CD	MCD
1 Loss of Father	2	1.6	3	2.7	3	2.3	+	+	6.6
2 Loss of Mother	0	2.7	1	4.6	2	4.0	-	-	11.3
3 Loss of both parents	0	0.8	2	1.2	2	1.0			3.0
4 Ill health of parents	6	3.1	5	5.2	4	4.4			12.7
5 Parents unmarried	6	5.4	12	9.1	8	8.0			22.5
6 Neglect (care and protec- tion, custody orders, N.S.P.C.C.)	5	5.1	9	8.6	5	7.4			21.1
7 Desertion by either parent or separation of parents	2	2.1	1	3.5	1	3.0	-	-	8.5
8 Behaviour problems (be- yond control, etc.)	1	1.3	2	2.3	1	2.0	-	-	5.6
9 Poverty	3	2.5	5	4.3	7	3.7	+	+	10.5
Number of Young Men**	13	-	22	-	19	-			54
									-

* Expected if reasons for admission were distributed in the same way as among all young men by whom the questionnaire was returned.
 ** This figure is not the sum of the figures in the column above because a young man may be admitted for several reasons.

been admitted because he lost his mother (Cat. 2), because his parents deserted or separated (Cat. 7), or where the reason for admission resulted from behaviour problems (Cat. 8). The difference between observation and expectation was statistically significant only where loss of mother was the reason for admission, the effect being increased when the groups are amalgamated as in Table 1, c. Thus, of 54 cases of ulcer or dyspepsia, 3 young men were actually found in Cat. 2 in contrast to 11 'expected'.¹

In order to make sure that this finding corresponded to the actual life experiences of the boys, and was not an artefact resulting from the use of a crude system of classification, we obtained permission from Barnardo's to read short case summaries (in which all identification data, such as names, towns, organizations, etc. were deleted) of the 35 cases found to have an ulcer or chronic dyspepsia. We also read the histories of a control sample of 35, consisting in each case of the boy admitted to Barnardo's immediately after the ulcer or chronic dyspeptic case who had replied. Comparing these histories, the finding about the relative infrequency of 'motherlessness' among the dyspeptics was upheld.

Table 2	PRESENCE OF MOTHERS			
	Ulcer	Chronic Dyspepsia	Total U+CD	Controls
With mother till admission	10/13	12/22	22/35 (63%)	13/35 (37%)

(Testing the trend in the proportion with mother till admission from ulcer through chronic dyspepsia to controls, $\chi^2 = 2.50$; $p < .015$, c.f. Armitage (1955).)

1 TESTS OF SIGNIFICANCE FOR CATEGORY 2

Group	(a) Chance of obtaining as few as observed or fewer (one-tail test)	(b) Chance of obtaining a deviation from expectation as great or greater (two-tail test)
Ulcer (13)	0.055	0.154
CD (22)	0.048*	0.104
MCD (19)	0.237	0.400
U plus CD (35)	0.004**	0.018*
CD plus MCD (41)	0.024*	0.048*
U plus CD plus MCD (54)	0.003**	0.010*

* Significant at 5 per cent level. ** Significant at 1 per cent level.

The different combinations of ulcer, chronic dyspepsia, and mild chronic dyspepsia are shown to enable the reader to make an assessment of the significance of the figures in Table 1 from various points of view. There is no implication that significance is enhanced by the fact that several different permutations show differences that are significant at the conventional 5 per cent level. There is the additional point that these tests applied to one category out of nine, the remainder of which do not show significant differences. This may be justified by the relatively high levels of significance reached and by the fact that Category a is related to the chief hypothesis of the main study.

Interpretation of Results

The findings that among those who had lost their mother significantly fewer men had an ulcer or dyspepsia than was to be expected, and that on closer scrutiny more boys with an ulcer or dyspepsia lived with their mothers till admission than in the control sample, contradict our original hypothesis that the occurrence of ulcer is highly correlated with separation from the mother. It is, however, consistent with the results of the clinical family study and the indications from the projective test material, namely that there is a closer relationship between the boys and their mothers in the D U sample than in the control sample. Thus the suggestion—arising from the clinical material in the main investigation—that a close prolonged relationship with the mother is important in forming the personalities of dyspeptics, seems to be supported by this small statistical inquiry among this generally deprived group of children.

The other findings in relation to reasons for admission, in which the differences are slight and by no means statistically significant, are of interest only because they, too, point in the same direction as the findings of the main clinical study. Those young men who were admitted because of desertion by or separation of parents had fewer ulcers and less dyspepsia than expected, which again supports the suggestion that the disruption of family relationships is not a crucial factor in dyspepsia or ulcer. Those young men who were admitted because of behaviour problems also had slightly less dyspepsia than was expected. This suggestion fits in with our clinical finding that the majority of boys who later developed duodenal ulcer showed 'good' conforming behaviour in childhood, and lack of overt aggression, in contrast to the boys in the control sample who showed more aggressive behaviour in childhood. It is also consistent with the findings of the Thematic Apperception Test, which suggest that the young men with duodenal ulcer express less aggression in fantasy than the young men in the control sample (see Appendix I).

Turning to the categories in which the young men had more ulcers and dyspepsia than expected, the survey again seems to support suggestions from the main clinical study, which showed that the boys in the D U sample had a more distant relationship with their fathers, and were less inclined to identify with them than were the controls. The results in Table 1 give only a very slight indication; but the more detailed study of the 35 cases of ulcer and chronic dyspepsia and 35 controls from the Barnardo population, indicate that the father was absent much more frequently in the ulcer than in the control group.

Table 3 ABSENCE OF FATHERS

Father dead or absent for several years	Ulcer	Chronic Dyspepsia	Total U+CD	Controls
	10/13	12/22	22/35	15/35
			63 %	43 %

χ^2 (with trend, see Table 2) = 2.07; $p < .04$

Ulcers occurred more frequently than expected in boys admitted for poverty (Category 9) which presented a puzzling finding at first, as none of the studies so far carried out indicate that there is a relationship between poverty and duodenal ulcer (though the incidence of gastric ulcer rises with the fall in social class). The finding became more intelligible when it emerged that poverty often coincided with the absence of the father either directly (Cat. 1) or indirectly through illegitimacy (Cat. 5).

Conclusions

In conclusion it must be stressed once more that the validity of this inquiry is impaired by the fact that less than two-thirds of the young men in this age group had addresses available and that of those less than two-thirds responded to the questionnaire. The number of cases is also very small and the findings and interpretations can be regarded as only very tentative. It is, however, remarkable how well they fit in with the findings of the clinical study of the family background of young men with duodenal ulcer and it is satisfactory that none of the suggestions arising from this small statistical survey seem to contradict any of the clinical findings. It is suggestive that the one significant finding of the survey, that ulcers and dyspepsia were less common than expected among those who lost their mothers, should correspond with the most striking clinical finding of the all-pervasive influence of the mother and the boy's close relationship to her.

This small survey also illustrates the complementary use that can be made of survey and case-study methods, using one method to test hypotheses or to illuminate findings emerging from the other.

Acknowledgements: We are much indebted to the Executive Staff of Dr Barnardo's Homes and especially to Mr T. F. Tucker, Assistant General Superintendent, without whose continuous and enthusiastic cooperation this survey could not have been carried out. We are also very grateful for the help and advice of Mr J. A. Heady, Statistician to the Unit.

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APPENDIX V

Questionnaire to Mothers on Child-Upbringing

WRITTEN IN COLLABORATION WITH VICTOR B. KANTER

The findings in the main study were based on information given in interviews by the parents or by their sons. Their information about events and attitudes twenty years ago could, at best, indicate the informants' present views of past experiences. We therefore tried a different approach to ascertaining the mothers' attitudes to child-rearing by means of a simple projective test which, we hoped, might reflect the mothers' actual attitudes and practices in the past. In this test, the mother was asked to imagine herself giving advice based on her own experience to a young wife who was expecting her first baby. This young woman would ask her a number of questions about the first five or six years of childhood. These were presented in a questionnaire, which, it will be seen, deals mainly with the mother's practices in rearing her child. There were 72 questions (the first 3 for practice), to which standard answers (alternative or multiple choice) were provided.

The questionnaire, which took on average 25 minutes to complete, was given by the P.S.W. to the mothers, who usually answered it in her presence.

Of the 32 families in each sample, 27 mothers in the DU and 21 in the control sample answered the questionnaire. The reasons for the failures were:

	DU	Control
Mother dead or absent	4	5
Mother refused	—	3
Questionnaire not offered (precarious relationship, or other complications)	5	3
Total	9	11

It should be stressed that the P.S.W. was chiefly interested in getting the necessary information in interviews, and when she thought that the questionnaire might impede this, she omitted it. In the analysis, only simple comparisons between individual items were made. The material does not justify more elaborate statistical treatment because the numbers tested were small; they constituted about two-thirds of each sample, and might therefore not be truly representative; the conditions of testing were not exactly the same for both samples

or for all the individuals in one sample. We are, however, reporting the results not so much because of the differences between the DU and control groups, which are only suggestive, as because of the remarkable similarities that will probably be of interest to those more generally concerned with mothers' attitudes to child-rearing. We also think it worth while to demonstrate a method of investigation that is not without promise and might repay fuller exploration.

For purposes of discussion we have classified the responses in three main categories.

- A. *Majority Agreement*: If there was a two-thirds majority of those answering either 'Yes' or 'No' in both groups (DU and Control) and if these majorities agreed with each other. More than half the items fall into this category.
- B. *Similar Divisions of Opinions*: If there was a division of opinion within each group but no clear differences between the groups (no two-thirds majority in either group, with the difference between groups in 'Yes's' and 'No's' being less than 5).

When there was a choice of more than two alternate answers, the responses were treated, somewhat arbitrarily, as though a simple alternative had been required.

These items are marked with a dagger (†) in the questionnaire below.

- C. *Differences of Opinion between DU and Control Groups*: If there was a difference between the groups of 8 'Yes's' or 'No's'. The figure 8, is arbitrarily chosen, but roughly corresponds to the 5 per cent level of significance. (However, there were only 5 such items among 72 that could well have occurred by chance.)

These items are marked with an asterisk (*) in the questionnaire. (N.B. Certain questions were omitted by some of the mothers.)

REPLIES TO QUESTIONNAIRE

The questionnaire had the following introduction:

Will you please imagine that a young wife who is expecting her first baby has come to visit you. She has read some articles on babies, has been to the Clinic, and has listened to several talks on the wireless, but now she has come to you for personal advice.

She very much wants to know your opinions which you have formed through your own experience as a mother. At present she is mainly interested in the early years of childhood up to the age of five or six.

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Of course she knows that there cannot be right or wrong answers to all these questions, and that different mothers have different ideas.

Below is a list of questions she is going to ask you. The answers are printed by the side of the questions, and all you have to do is *put a ring round the answer which is closest to your own opinion*. Here's an example:

Are cod liver oil and orange juice good for baby? Yes No

If you feel you *cannot* answer the question by putting a ring round one of the printed answers, please *write* 'can't say' instead.

Don't leave out any questions and just go straight through them without stopping.

	YES	NO
	DU C	DU C
1 Is mother's milk good for baby?	22 20	1 1
2 Do young babies need a lot of sleep?	23 21	0 0
3 Will the baby thrive better on breast than bottle?	21 19	1 2
4 Should I keep to a fixed time-table in feeding baby?	14 9	9 12
5 Should I start potting the baby regularly from birth?	17 18	6 2
† 6 Should I expect my husband to help me with the baby?	14 14	9 7
7 If the baby cries at night, should I leave him alone?	4 6	18 15
8 Should I give baby a dummy to keep him quiet?	5 6	17 15
9 If there are any feeding difficulties, should I—		
(a) try a different way of feeding baby?	7 8	
(b) ask someone in the family?	0 3	
(c) ask a doctor?	16 10	
10 If I feed the child at the breast, should I do this for—		
(a) three months?	2 0	
(b) six months?	5 4	
(c) six-nine months?	15 15	
(d) over nine months?	1 2	
† 11 If he sucks his thumb in the first two years, should I put a stop to it?	11 13	11 8
12 Should I start potting baby regularly at—		
(a) three months?	6 11	
(b) six months?	2 1	
(c) nine months?	0 0	
(d) later than nine months?	1 0	
(e) before he is three months old?	14 9	
13 If the baby does not sleep at night, should I rock him in my arms?	6 6	17 14

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YES NO
DU C DU C

- *14 Should I feed baby whenever he seems hungry? 7 15 15 6
- †15 Should I expect baby to have a dry bed at—
- (a) nine months? 5 5
 - (b) one year? 6 6
 - (c) fifteen months? 2 1
 - (d) eighteen months? 4 3
 - (e) two years? 2 5
 - (f) later? 0 1
- 16 Should I expect father to help in giving baby his meals? 12 8 10 13
- 17 Should I give baby opening medicine or powder regularly once a week? 10 16 12 5
- *18 Should I worry if baby isn't yet talking at—
- (a) one year? 5 5
 - (b) eighteen months? 5 12
 - (c) two years? 12 4
- 19 Should I expect difficulties in weaning baby? 6 3 17 18
- †20 Should I expect unsoiled nappies at—
- (a) nine months—one year? 12 13
 - (b) fifteen months? 6 1
 - (c) eighteen months? 4 5
 - (d) two years? 0 2
- 21 If baby goes 24 hours without a bowel movement, should I do anything about it? 18 20 5 1
- †22 If I have to go away, would it be all right for me to leave baby for one month or more—
- (a) in the first year? 6 7
 - (b) in the second year? 7 4
 - (c) in the third year? 8 4
 - (d) between three-five years? 6 3
 - (e) after the fifth year? 8 2
- 23 Should I wean the baby by giving solids together with his milk and gradually increasing the solids? 22 21 1 0
- 24 Should baby share our bedroom for the first—
- (a) three months? 1 6
 - (b) six months? 3 2
 - (c) first year? 6 9

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	YES		NO	
	DU	C	DU	C
(d) eighteen months?	2	1		
(e) more than eighteen months?	3	3		
(f) less than three months?	8	0		
†25 Will it matter if I haven't the time to keep a record of the child's weight?	12	14	11	7
*26 If the child wets the bed at night after two years, should I—				
(a) leave him alone?	0	1		
(b) try harder to train him?	5	12		
(c) ask a doctor?	18	8		
(c) seek advice in the family?	0	0		
27 If baby has soiled nappies after eighteen months, should I—				
(a) ignore it?	3	3		
(b) put him on the pot more often and keep him there longer?	20	18		
†28 Supposing I can find someone to look after the child, will it be all right for him if I go out to work part time—				
(a) in his first year?	4	5		
(b) in his second year?	3	5		
(c) in his third year?	4	3		
(d) in his fourth year?	0	2		
(e) in his fifth year?	8	5		
29 If the child will not eat, should I—				
(a) coax him?	17	16		
(b) be firm and insist?	2	3		
30 Will it be all right for the child if he continues to sleep in our bedroom after the age of three?	5	5	18	16
31 Should I insist upon the child's using the pot at a regular time of the day?	17	20	6	1
32 Supposing I can find someone to look after the child, will it be all right for him if I go out to work full time—				
(a) in his first year?	3	3		
(b) in his second year?	2	2		
(c) in his third year?	4	3		
(d) in his fourth year?	0	2		
(e) in his fifth year?	9	7		

APPENDIX V

YES NO
DU C DU C

- | | | | | |
|---|----|----|----|----|
| †33 Should I expect father to bath the child sometimes? | 13 | 10 | 10 | 11 |
| 34 Is it a good thing for my child to go to a nursery school? | 20 | 17 | 3 | 4 |
| †35 If I do send my child to a nursery school, what is the best age— | | | | |
| (a) two years? | 6 | 2 | | |
| (b) three years? | 8 | 7 | | |
| (c) four years? | 8 | 10 | | |
| 36 At what age should I expect the child to be able to dress himself? | | | | |
| (a) three years? | 2 | 3 | | |
| (b) four-five years? | 15 | 13 | | |
| (c) five years or later? | 6 | 3 | | |
| †37 If the child, before he is five, asks where babies come from, is it all right to tell him the stork or gooseberry-bush stories? | 13 | 14 | 10 | 7 |
| 38 If he won't go on the pot, should I promise him a sweet to get him to do it? | 5 | 10 | 18 | 11 |
| *39 Should I allow the child to eat between meals? | 2 | 8 | 21 | 13 |
| 40 Should I teach the child to believe in God? | 23 | 29 | 0 | 2 |
| †41 Is it all right to hit the child when he is naughty? | 11 | 8 | 12 | 13 |
| 42 If he asks about the difference between boys and girls, should I explain it to him? | 20 | 16 | 3 | 5 |
| 43 Should I teach the child to say his prayers? | 23 | 20 | 0 | 1 |
| †44 If he has a little girl playmate, is it all right if they have their baths together when they are five years old? | 12 | 10 | 11 | 11 |
| 45 If he asks where babies come from, should I tell him that babies grow inside mother? | 14 | 9 | 9 | 12 |
| *46 Will I spoil the child if I cuddle and kiss him a lot? | 3 | 9 | 20 | 11 |
| 47 Should I make the child wash his hands before meals? | 23 | 21 | 0 | 0 |
| 48 If the child throws a temper tantrum, should I— | | | | |
| (a) be firm and put a stop to it? | 8 | 13 | | |
| (b) try to comfort him? | 11 | 7 | | |
| 49 Will it harm the child if he plays with his sexual organs? | 20 | 20 | 1 | 1 |

FAMILY INFLUENCES AND PSYCHOSOMATIC ILLNESS

	YES DU C	NO DU C
50 Will it be all right for the child to see me having a bath?	6 7	17 14
51 If there is a new baby, should I worry if he is very jealous of it?	10 14	13 7
52 If he asks what part father plays in producing a baby, should I—		
(a) get him off the subject?	7 2	
(b) try to explain?	3 2	
(c) tell him to wait till he is older?	13 17	
53 If he forms any bad habits should I try to stop it by promising him a present?	2 4	21 17
† 54 If the child won't eat the food I give him, shall I go and get him something else?	9 8	14 13
55 If the child won't do as he's told, should I—		
(a) coax him?	3 6	
(b) be firm?	20 15	
† 56 'Spare the rod and spoil the child'—is this true?	11 8	11 12
57 Should I tell the child that playing with his sexual organs is wrong?	21 20	2 1
58 If he seems to be jealous of his father, should I—		
(a) take no notice?	6 6	
(b) tell him it is wrong?	5 9	
(c) try to be specially nice to the child?	12 5	
59 If he is jealous of the new baby, should I be firm and try to stop this?	13 18	10 3
60 If he likes particularly messy games, should I—		
(a) take no notice?	17 10	
(b) insist on him playing a cleaner game?	5 11	
61 Shall I lift him regularly during the night until he is—		
(a) three years old?	19 19	
(b) four years old?	0 1	
(c) five years old?	0 0	
(d) six years old?	1 0	
62 If the child has to be punished, should I—		
(a) do it myself?	23 18	
(b) get his father to do it?	0 3	

YES NO
DU C DU C

63	If he is rude to me, shall I—				
	(a) be firm with him?	19	17		
	(b) ignore it?	3	4		
†64	If I find him taking his toys to pieces, shall I—				
	(a) leave him alone?	12	9		
	(b) stop him?	11	12		
65	If he uses bad language, shall I—				
	(a) ignore it?	7	6		
	(b) forbid it?	5	8		
	(c) ask him not to because people won't like it?	13	7		
†66	Supposing I find out that he and the little girl next door have been comparing their bodies, shall I—				
	(a) forbid it?	12	12		
	(b) punish him?	1	4		
	(c) ignore it?	8	5		
67	If he makes up fairy stories about himself, should I tell him to tell the truth?	12	18	10	3
68	If he won't say 'please' and 'thank you' when he is five, shall I tell him I won't give him anything more unless he does?	21	18	2	3
69	If he is always breaking things, should I—				
	(a) smack him?	0	3		
	(b) scold him?	1	1		
	(c) leave him alone?	0	1		
	(d) talk to him?	22	16		
70	Should I expect him to show appreciation for all that his father and I do for him?	14	16	9	5
71	In bringing up young children, should one be—				
	(a) firm on the whole?	16	14		
	(b) easy-going on the whole?	7	7		
72	Should I allow the child to answer me back?	9	0	23	21

Summary and Discussion of Results

This questionnaire on child-rearing revealed a number of opinions held by most mothers in both samples that may be 'stereotypes' in the culture in which they live. These are of some interest. Most of the mothers advise breast-feeding for 6 to 9 months (see Question 10) and advocate regular toilet-training from birth (see Question 5). They think the difference between the sexes should be

FAMILY INFLUENCES AND PSYCHOSOMATIC ILLNESS

explained to the child (see Question 42) but are not in favour of telling him about the father's part in reproduction (see Question 52). (As for mother's part in the process, almost as many are against explanation as are for it.) They agree almost unanimously that masturbation is harmful (see Question 49) and the child should be told it is wrong (see Question 57). In matters of discipline they are in favour of firmness (see Questions 55 and 71), require politeness from the child (see Question 68), and feel that the mother should punish the child and not get the father to do it (see Question 62). They say a baby's crying at night should not be ignored (see Question 7). They are almost all advocates of education in religion (see Question 40). They think nursery schools are good for children (see Question 34).

It is not easy to relate these apparent stereotypes to the attitudes revealed in interviews, which allowed much more scope for flexibility and variability of opinion. On the whole, the general attitudes to cleanliness-training and the stress on the mother as the main socializing influence were also reflected in the interview material. On the other hand, that the great majority of mothers should advocate firmness in bringing up young children seemed inconsistent with their reports of what they had done. It is possible that 'firmness' constituted an ideal in the presence of much actual uncertainty in matters of discipline, for most of the questions dealing with this field showed division of opinion within the groups. The general disapproval of masturbation is of special interest for it was not voiced in the interviews. Whenever this topic came up most of the mothers gave the impression of not attaching great importance to it and of having dealt with it in a matter-of-fact way.

If we compare some of the attitudes implicit in the more stereotyped answers to the questionnaire with modern theories of child-upbringing which owe so much to the psycho-analysts, the child psychologists, and to the cultural anthropologists, we are forced to think that the opinions and prejudices of these mothers have hardly been touched by the views of the 'experts'. For instance, strict and early toilet-training is held by many psychiatrists and psychologists to be an important determinant of obsessional character traits and even, in some circumstances, of obsessional neurosis. Contrary to most modern experts, ranging from fairly orthodox paediatricians (Illingworth, 1953) to psycho-analysts (Isaacs, 1953, p. 112) and to the counselors in women's magazines,¹ the mothers think that the child should be told that masturbation is wrong. However, there is a good deal of conflicting opinion among the mothers as to how to deal with the child's sexual curiosity. For instance, they all agree that the child should be told about the differences between the sexes, but are less in favour of his making his own investigations (see Question 66). Here we can perhaps detect the influence of new insights working upon some of the older stereotypes. It was interesting that very many more mothers in both groups

¹ See, for example, Anne Cuthbert's articles in *Housewife*.

advised telling children about the origin of babies than had in fact done so (see Question 45). It is, of course, quite possible that some of the answers reflect current teaching on these matters.

Similar divisions of opinion *within* the two groups are interesting too; they may indicate changing attitudes about topics on which common views are no longer held. Thus it looks from the answers as though there are changes in attitude to likes and dislikes in food and to thumb-sucking, etc. in the direction of easier gratification (see Questions 11 and 54), particularly if one remembers that these mothers brought up the sons whom we studied during the Truby King era.

In matters of discipline, while firmness is the aim, there is much uncertainty in both groups about the ways and the situations in which firmness is to be expressed. There is also some difference of opinion as to the extent to which affection should be physically expressed. Similarly, opinions are divided about the father's role and the desirability of mother going out to work, showing how even in these small groups of women from a similar social background, norms of behaviour and social roles seem to be in a state of flux.

In the majority of the items (48), there were thus no appreciable differences between the two groups, and the interest of the answers to these lies in the way in which they reveal commonly held opinions in some fields and divergent views in others.

Notable differences of opinion between the groups occur in but a few items. The mothers in the control sample advised more indulgent and flexible behaviour over feeding (see Questions 14 and 39) and less dependence on the expert in matters of feeding and toilet-training (see Questions 9 and 26). Conversely, the mothers in the DU group revealed in their attitudes more dependence on strict routine in feeding, and on the advice of the expert.

This difference supports the findings of the clinical study in some respects but not in others. The interviews did not suggest that the mothers in the control group were more indulgent over feeding. There were some indications, however, that the mothers in the DU sample remembered breast-feeding as either a very positive or very negative experience, whereas the mothers in the control sample did not show these extremes in attitudes. On the other hand, the indication from the questionnaire that the DU mothers were believers in rigid routine and relied more on advice from the expert is consistent with the suggestions from the clinical study that they showed greater anxiety and protectiveness towards their children and were more rigid in their dealings with them, while the mothers in the control sample were more flexible and easy-going. Another marked difference, namely that the mothers in the DU sample were more ready to permit kissing and cuddling than the mothers in the control sample (see Question 46), may be related to the finding in the main study of the greater physical and emotional closeness of the DU mother to her son.

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On the whole, then, this questionnaire did not help us very much in detecting differences in attitudes to child-rearing between the two samples of mothers or in supporting the differences that seemed to emerge from the clinical study. There may be many reasons for this: significant differences may not in fact exist between these two samples of mothers in their attitudes to child-rearing, which would suggest that the findings of the main study were in part determined by chance or by observer-error; the questionnaire samples may have been too small or too unrepresentative to reveal differences that did exist; questionnaires that necessitate yes/no answers on topics loaded with emotion may force the respondents into stereotyped answers, while prolonged and repeated non-directive interviewing may eventually get at the subject's real attitudes; it is quite possible for mothers to give advice as a result of experience that may be contrary to their own earlier practices and even to their inner convictions. Having said all that, we still think it is noteworthy that the questionnaire has indicated some differences between the groups in relation to oral gratification. If this finding were to be confirmed in a larger sample it would lend some support to the psycho-analytic hypothesis that oral frustration in infancy may sometimes be a relevant factor in the aetiology of duodenal ulcer.

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APPENDIX VI

The Family Background and Childhood Behaviour of Delinquents, Duodenal Ulcer Patients, and 'Normal' Controls

A COMPARATIVE STUDY

Background of Study

The suggestion emerging from the main study that the family background of young DU patients is one of respectability, closeness of emotional ties, and maternal protectiveness is in great contrast to the notions associated with the family background of delinquents, such as broken homes, maternal deprivation, and open parental discord. It was thought, therefore, that a comparison of the family background of young delinquents and young DU patients might illuminate the relationship between specific family influences and the child's personality development and possible later disturbance.

As it proved impossible to gain direct access to a comparable sample of delinquents in the same age group, Dr G. H. Stott, whose study of 102 delinquents and their families had been published under the title *Delinquency and Human Nature* in 1950, generously agreed to make his material available. Dr Stott's sample is not strictly comparable as his young men come from many parts of Britain and they were younger (aged 15-18). It may also be biased in relation to the home background, the nature of which might have been a decisive influence in sending the boy to an approved school. However, suggestions emerging from other studies and some of the evidence produced in the Nuffield inquiry on the causes of crime lead me to suppose that the family backgrounds and the behaviour patterns found among Stott's delinquents are characteristic of the general run of serious delinquents. Despite obvious shortcomings, then, Dr Stott's sample constitutes a complete series of persistent delinquents who were studied in the order in which they entered an approved school 'somewhere in England'. A comparison of their family backgrounds with those of the young DU patients and the controls, though not strictly valid, may give pointers for further more carefully controlled study.

An attempt was made to compare the delinquent group with the DU and control samples on some of the characteristics that were discussed in the main study. For the delinquents many of these characteristics had already been defined and rated by Dr Stott in the statistical summary attached to his book; and

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in order to enable me to compare the three samples on other items which were not analysed in this summary he kindly made available to the Unit shortened case histories of all the 102 delinquents. Since the detailed results of these comparisons will be discussed elsewhere, a summary only is given in this Appendix.

Social Background and Family Structure

A greater number of the delinquents came from socially inadequate conditions. These appeared to be related mainly to the failure of the paternal breadwinner to function adequately (absence of father or inability to work) and to some extent to the inability of both parents to provide adequate material and psychological conditions for their children. The delinquents came from larger families than the DU patients and controls, and only children were less common among them.

The greatest differences between the groups were apparent in the loss of a parent by death, desertion, or parental separation. Over half the delinquent boys suffered the virtual loss of one parent. Once more the 'broken home' as a background of delinquency was demonstrated, although one should not ignore the fact that about 15 per cent of the young men in the DU sample also suffered from a broken home. The absence of the father was the largest single factor in the broken home of the delinquent, showing a gradient from the delinquents (33 per cent) through the DU patients (16 per cent) to the controls (6 per cent). None of the boys in the DU and control samples lived in an institution under the age of five while six of the delinquents did so. Similarly 16 per cent of the delinquent boys were in foster homes during their childhood, whereas none of the boys in the DU and control samples had this experience.

The absence of a permanent mother-figure during childhood was also pronounced in the delinquents. Nearly a quarter of the boys were subjected to this experience as against 3 per cent in the DU and 9 per cent in the control samples, the sharpest differences emerging in the absence of continuous maternal care in very early childhood.

Parent-Child Relationships

The amount of disturbance found in the mother-son relationships was similar in the DU and delinquent samples and appreciably less in the control sample. The nature of the disturbance, however, differed in the DU and delinquent group and it was as a rule far less obvious in the DU sample. Over one-third of the mothers of delinquents showed lack of affection in their attitudes to the boys. Two-thirds of these affectionless mothers were openly hostile to their boys, which often resulted in an emotional rejection of the mothers on the boys' part. While lack of indulgence on the mothers' part and a certain defensiveness

in the boys' was also a feature in the DU families, it was less common and less severe when it did occur. Only very rarely was this kind of relationship found in the control sample. Somewhat unexpectedly, over-indulgence was not only a prominent feature in the attitudes of DU mothers but it was also found in a quarter of the delinquent mothers, though it was different in kind from that of the DU mothers; whereas the over-indulgence in the delinquent group was often associated with weakness and a kind of 'emotional starvation' in the mother, in the DU sample it was associated with dominance and powerful maternal feelings. The resultant emotional dependence was also different in the two groups, the delinquents rallying to their mothers' aid against an unsatisfactory father and the DU boys remaining dependent and demanding 'babies'.

The comparative picture of the father-son relationship in the three samples shows a trend from frequent absence, broken or predominantly negative relationships in the delinquent sample, through less broken but rather distant and neutral relationships in the DU sample to predominantly unbroken and positive relationships in the control sample. The very disturbed nature of the father-son relationships among delinquents has also been observed in other studies, both in this country and in America.

The Mental Health of the Parents and their Marital Relationships

A greater proportion of the fathers in the delinquent group seemed emotionally disturbed than in the DU and control groups and their disturbance often took the form of pathological aggression. This suggests that the personalities of the delinquents' fathers were very different from the peace-loving, plodding and conscientious majority of fathers found in the DU and control samples. Although the mothers in the delinquent sample suffered more physical ill health the amount of emotional disturbance found was roughly equal in the delinquent and the DU group; however, the severity and the nature of the disturbances differed greatly. The impression was gained that many of the disturbed mothers in the delinquent group were poorly integrated and socially ineffective personalities who were at odds with their environment. The mothers in the other two samples, though they might have been neurotic in some respects, seemed to have more integrated personalities and were able to order their lives more effectively. While half the marriages in the DU sample and two-thirds in the control sample were rated as 'harmonious', this only applied to at most a third of the marriages in the delinquent group. Almost a quarter of the marriages ended in separation or divorce in the delinquent group compared with 15 per cent and 12 per cent in the DU and control groups respectively. In the outwardly stable but precarious marriages which form a similar proportion of the delinquent and DU samples, 'quarrelling' was an outstanding characteristic among the parents of delinquents, whereas the tensions and incompatibilities between the parents of the DU patients were far more submerged.

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The Boys

Not unexpectedly the delinquent boys were found to have lower average intelligence than the boys in the other two samples and a much smaller percentage of delinquents attended grammar or technical schools than in the DU or control samples.

It seemed that the physical and mental health of the delinquent boys as shown by definite symptoms was worse than the health of the children in the DU and control samples. However, anxiety and fears did not differentiate between the three groups. The contrast between the delinquents and the DU boys was most marked in behaviour related to aggression and withdrawal. The delinquents seemed to react to their more seriously disturbed and often rejecting environment with aggressive and withdrawing behaviour, the withdrawal being characterized by wandering and solitariness.

Conclusion

In many aspects of family relationships a trend was perceptible of greatest disturbance in the delinquent sample, less in the DU sample, and considerably less again in the control sample. Apart from the quantitative factor the nature of the family disturbances also appeared to be different. A characteristic tightness of family ties could be observed in the DU sample which was fostered by a possessive mother in the centre, and by conscientious devotion to duty on the part of both parents. Though anxiety and tensions may have been present, hostility was rarely expressed openly. In the delinquent families ties were frequently broken or very tenuous and standards of care inconsistent or indifferent. Hostile and negative feelings were frequently expressed. The DU boy seemed to react with predominantly compliant and unaggressive behaviour to the parental protection and careful training, keeping close to his mother, though he might have felt some frustration and resentment beneath the conforming surface. The delinquent boy appeared to act out his frustration and disappointment in openly aggressive behaviour and in an emotional or actual flight away from his painful setting.

Finally, these comparative data have highlighted some problems surrounding the father-son relationship. Whereas much attention has recently been paid to maternal deprivation as a causative factor in delinquency and personality disorders, paternal deprivation seems to have been relatively neglected although this study and others (Andry, 1955; Glueck, 1950, pp. 108-15; Bennett, 1950; Merrill, 1948, p. 66) indicate that this factor may be of great importance, and merits more careful attention.

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